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RYAN WHITE HIV/AIDS TREATMENT MODERNIZATION ACT OF 2006

SEPTEMBER 28, 2006.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. BARTON of Texas, from the Committee on Energy and Commerce, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 6143]

[Including cost estimate of the Congressional Budget Office

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 6143) to amend title XXVI of the Public Health Service Act to revise and extend the program for providing life-saving care for those with HIV/AIDS, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

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PURPOSE AND SUMMARY

The purpose of the Ryan White HIV/AIDS Treatment Modernization Act (RWHATMA) is to address the unmet care and treatment needs of persons living with HIV/AIDS by funding primary health care and support services that enhance access to and retention in care. RWHATMA reaches over 500,000 individuals each year, making it the Federal Government's largest discretionary grant program specifically for people living with HIV/AIDS.

Like many health problems, HIV/AIDS disproportionately affects people in poverty, racial/ethnic populations, and others who are underserved by healthcare and prevention systems. HIV/AIDS often leads to poverty due to costly healthcare or an inability to work that is often accompanied by a loss of employer-related health insurance. RWHATMA-funded programs are the "payer of last resort." They fill gaps in care not covered by other resources. Most likely users of RWHATMA services include people with no other source of healthcare and those with Medicaid whose care needs are not being met.

RWHATMA services are intended to reduce the use of more costly emergency services and inpatient care, increase access to care for underserved populations, and improve the quality of life for those infected or affected by the epidemic. It funds local and State programs that provide primary medical care and support services; healthcare provider training; and technical assistance to help funded programs address implementation and emerging HIV care need. RWHATMA allows for significant local and State control of HIV/AIDS healthcare planning and service delivery that has led to many innovative and practical approaches to the delivery of care of people living with HIV/AIDS.

The bill has a variety of provisions, the explanation of and committee views on which follow below:

A. PROVISIONS APPLICABLE TO SEVERAL TITLES

Although the last reauthorization of the CARE Act specified that the formula distributions in Parts A and B would be based on HIV (not AIDS) and AIDS cases, beginning in fiscal year 2007, several States had not yet switched to names-based HIV reporting. Therefore, those States did not have case counts that could be certified by the Centers for Disease Control and Prevention (CDC). Thus, the Committee provided a particular mechanism to all those States to submit data to the Health Resources and Services Administration (HRSA), not certified by the CDC, in lieu of their names-based HIV data counts. In providing this mechanism, the Committee wanted to continue to encourage those States to switch to names-based HIV reporting, as well as ensure that by fiscal year 2011, all States would use names-based CDC-accepted HIV and AIDS cases for formula distributions.

The Committee understands that States which currently collect data on persons with HIV that has not progressed to AIDS in a code-based format will need to convert their systems to one that is names-based. Particularly in large States, this may be a difficult and time-consuming process. Under the terms of the Committee

bill, funds distributed in fiscal year 2011 will be based on data collected through December 2009.

In order to reflect the actual incidence of HIV as fairly as possible, the Committee recognizes that the Department will necessarily need to be more flexible in determining that accurate names-based data is being produced in States making the transition.

If the State has a system for collecting data that has been agreed to by the CDC, and has begun their collection, the Committee intends that as names-based cases are collected, they would be added to the count of actual living AIDS cases. In addition, the Committee intends that all current code-based States could continue to use their code-based data through fiscal year 2010. The Secretary, in consultation with the chief executive of the State in which the eligible area is located, can determine that a system has become operational in the State that provides sufficiently accurate and reliable names-based reporting of such cases throughout the State. The Committee intends that the State must report HIV using a names-based system in scientific standards established by CDC to transition to a mature names-based system.

For the purpose of counting living non-AIDS cases of HIV in code-based reporting eligible areas, the Committee intends that the Secretary use cases reported to HRSA in 2005 for purposes of fiscal year 2007, in 2006 for purposes of fiscal year 2008, in 2007 for purposes of fiscal year 2009, and in 2008 for purposes of fiscal year 2010.

In February 2006, the Government Accountability Office (GAO) released a report entitled "HIV/AIDS: Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Funds." The GAO highlighted that "[f]orty-eight of the 51 EMAs would have received more funding if there had been no hold-harmless provision." Further, the GAO noted that the $1.6 million or seven percent of the Severe Need set-aside within the ADAP supplemental was used to provide Title II hold-harmless protection. Further, "[t]he potential exists for this Title II hold-harmless provision to diminish the size of Severe Need grants further in the future if larger amounts are needed to fund this hold-harmless protection." In recognition of these issues, the Committee opted to limit the hold-harmless provisions to five percent over the formula funding of the previous fiscal year for Part A and Part B during the fiscal years 2007 through 2009 after which it formally sunsets. Further, rather than provide the hold-harmless funding for Part B out of the AIDS Drug Assistance Program (ADAP) supplemental, the language explicitly requires that the funding first come from the Part B supplemental funding and then subsequently from pro-rata reductions. The Committee does not expect the pro-rata reduction provisions to be triggered. Rather, out of an abundance of caution, these provisions were included in the legislation. A similar mechanism exists for Part A in which the initial funding for the hold-harmless provisions is initially removed from the supplemental pool of funds and then subsequently from pro-rata reductions, with the expectation that no pro-rata reductions would be required.

The Committee notes that $9 million from Part A and nearly $68 million from Part B of funds appropriated during fiscal years 2000 to 2002 are slated to be returned to the Treasury. This represents

approximately 3 percent of the funds appropriated for Part A and Part B during this time period. Rather than have those funds revert to the Treasury, the bill clarifies the roles of the Secretary and the grantees to ensure that those funds are made available in the appropriate supplemental pools, while still allowing the grantee the option to have one more year to expend those funds.

The intent of this modernization of the Ryan White CARE Act is to improve access to medical treatment and care for individuals with HIV/AIDS. Today, with treatment, HIV/AIDS is a chronic but manageable disease. The goal of this reauthorization is to allow more individuals access to life-saving treatments.

To meet this goal, the legislation requires that 75 percent of Parts A, B, and C be spent on core medical services, which are specific medical care services that are essential to treating HIV/AIDS, unless the State provides evidence that these services are available to all individuals with HIV/AIDS identified and eligible under this bill. This funding will allow more people to learn their HIV status, and bring more people with HIV/AIDS into medical care.

It is intended that these funds go to services that specifically treat HIV infection, such as medical care and antiretroviral drugs. Congress recognizes that support services may impact the ability of people with HIV/AIDS to access care; however, HIV/AIDS is first and foremost a medical disease. In recognition of the need for States to retain some flexibility with regard to funding support services needed to achieve medical outcomes, the Committee authorizes that the remaining 25 percent of funds may be spent on support services that facilitate access to care.

In addition, at no time should the seeking and/or granting of a waiver by an eligible entity as outlined in sections 105, 201, and 301 be used to determine or impact an eligible entity's need or qualification for supplemental grant funds under the bill.

Within core medical services, many services such as medical case management and medical nutrition therapy are not defined. Consistent with the reauthorization's emphasis on medical care and treatment of HIV/AIDS, the Committee intends that the Secretary look to uses and definitions of similar terms such as primary care case management services and medical nutrition therapy services in Medicare and Medicaid. It is the intent of the Committee that registered dietitians or nutrition professionals with an equivalent education and training provide medical nutrition therapy under this bill.

The Committee offers additional guidance to its intent regarding the application of the core medical services requirement and services that may or may not fall within the defined list of core medical services. Specifically, nothing in the legislation shall be read as limiting the applicability of the term "Medical Case Management," in Sections 105, 201, and 301 to services given by a specific type of provider or given in a specific setting or location. The Committee recognizes that case management plays a vital role in ensuring that those living with HIV/AIDS have access to and remain in care and treatment. Accordingly, it is the Committee's intent that the provision of funds for medical case management, including treatment adherence services, as a core medical service in Parts A, B, and C shall include funding case management services that increase access to and retention in medical care. The Committee un-

derstands that such services often are or can be provided by a range of trained professionals, including both medically credentialed staff and other health professionals.

The Committee also recognizes that current medical standards of care for individuals with HIV/AIDS, as well as for those co-infected with hepatitis, include vaccination with hepatitis vaccines. The Committee intends that the definition of "outpatient and ambulatory health services" may include vaccinations, and instructs HRSA to make it clear to potential grantees that vaccination is a permitted use of funds under all parts of the legislation.

The Committee wishes to clarify that nothing in the legislation shall be read as limiting eligible support services to the examples listed in the text of the legislation in Sections 105, 201, and 301. The legislation delineates some examples of support services, but the five examples in the bill are not intended to be an exclusive list of possible support services. The Committee is aware of and received information supporting the validity of other examples of eligible support services that were not listed in the text. For instance, the Committee has received data to show that food and nutrition services as well as emergency and transitional housing may be needed for individuals with HIV/AIDS to achieve their medical outcomes.

In addition, the Committee recognizes that AIDS is increasingly impacting communities of diverse racial and ethnic backgrounds, presenting a variety of linguistic and cultural barriers to care. The Committee recognizes and applauds the efforts of AIDS service organizations to ensure delivery of linguistically and culturally competent care. The Committee intends linguistic services to be considered as support services for the purposes of funding allocation thereby recognizing language services are increasingly important to provide needed services to persons with limited English proficiency at risk of and living with HIV/AIDS.

Finally, with regard to case management, the Committee intends that case management that is not medical case management and is needed for individuals with HIV/AIDS to achieve their medical outcomes should be considered to be support services. The Committee therefore urges HRSA to recognize and support case management services that include, but are not limited to, helping HIV-positive individuals determine eligibility for and access to various medical and support services. Since the majority of HIV-positive individuals served by the Ryan White program live in poverty and often face multiple challenges, care coordination provided by case managers is essential to maximization of resources and healthy, productive lives.

Current HRSA guidance clarifies that entities providing Ryan White services need to require that members of a Native American tribe receive their services through the Indian Health Service. Therefore, to ensure that there was no question regarding the guidance, the Committee amended the payer of last resort provisions across Ryan White to make that exception clear.

In recognition that HIV infection is growing among Native American populations, the planning council representation and the statewide planning council requirements are amended to clarify that members of these planning bodies should include members of a Federally recognized Indian tribe as represented in the population.

Further, eligibility under Part C and Part D were amended to explicitly include health facilities operated by or pursuant to a contract with the Indian Health Service to ensure ongoing access to key HIV/AIDS services to Native American populations. Under Part F, the AIDS Education Training Center (AETCs) program was amended to clarify that AETCs should provide training that is relevant to Native American populations.

To ensure better accountability and transparency, the Committee wanted to encourage additional communication among the various entities funded under the RWHATMA. Therefore, the key item to assist with the promotion of that coordination was the requirement of the designation of a State lead agency to facilitate the coordination of programs under the RWHATMA. In particular, the State lead agency is to collect and compile an audit report every two years from each of the grantees under the RWHATMA, as well as put together specific outcome measures for the State. Every grantee in the State will need to report on those outcome measures, as well as any additional ones that the grantee would like to add. Further, although there is already a statewide coordinated statement of need process, the bill further clarifies that applications for awards to entities funded outside of Part B be consistent with the statewide coordinated statement of need process.

The Secretary should review and analyze funding dispensation to jurisdictions as it relates to those areas with the highest incidence or prevalence of HIV/AIDS, aggregated by race and ethnicity.

B. PROVISIONS APPLICABLE TO PART A

In February 2006, the GAO released a report entitled "HIV/AIDS: Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Funds." The GAO highlighted that, as of 2004, that "[m]ore than half of the eligible metropolitan areas (EMAs) received funding in fiscal year 2004 even though they were below Title 1 eligibility thresholds." In response to that information, the Committee opted to revise the provisions related to eligibility criteria to ensure that such inequity was diminished, while also providing a stabilizing force for those metropolitan areas. With that goal, the Committee created a two tier structure for all metropolitan areas: (1) tier one EMAs with 2000 or more AIDS cases reported during the last 5 years; and (2) tier two Transitional areas with at least 1000 but fewer than 2000 AIDS cases reported in the last five years. EMAs that received funding in fiscal year 2006 but were not eligible for tier one in fiscal year 2007 would be added to the tier two category. For all metropolitan areas, eligibility would be bifurcated in that eligibility would be granted immediately upon crossing the threshold criteria. However, if there was a declining number of AIDS cases, eligibility would be maintained until the metropolitan area was no longer eligible for three consecutive fiscal years based on both its incidence and prevalence AIDS case counts.

Further, in examining the growing rate of HIV/AIDS cases in smaller urban areas, the Committee decided that the additional requirement that metropolitan areas maintain a population threshold of 500,000 was unduly restrictive. Therefore, the Committee opted to remove the 500,000-population requirement but maintain the metropolitan area requirement of 50,000.

In further recognizing the need to provide greater stability for the care network for those with HIV/AIDS and that additional metropolitan areas would likely be eligible under the new criteria, the Committee maintained the current requirement that the boundaries for the metropolitan areas that received funding under Part A maintain their boundaries that were set in 1994. However, new entities would have their boundaries set at those that were in place at the time that they received initial funding under Part A.

To ensure that more funding is provided via funding formulas, the Committee shifted the total amount provided to Part A for formulas from 50 percent to 66⅔ percent. The supplemental pool is comprised of the remaining 33⅓ percent to be distributed first to fund any applicable hold-harmless provisions, then to fund the prioritization of supplemental award provision, and finally to fund additional supplemental awards for demonstrated need.

The Committee intends to focus the supplemental grant process more specifically on factors important to developing the severity of need index, factors which have implications of the amount of spending required per person with HIV/AIDS. The Committee expects that supplemental awards will be based solely on demonstrated need on a competitive basis, according to the criteria included in the legislation. The Committee emphasizes that the supplemental awards are not guaranteed nor are the levels of the awards per grantee guaranteed from year to year. In addition, the Committee strongly encourages the use of the factor related to the "impact of a decline in the amount received pursuant to subsection (a) on services available to all individuals with HIV/AIDS identified and eligible under this title" because the Committee expects, especially after the hold-harmless provisions are no longer in effect, that this will continue to provide a stabilization factor to communities that have a decline in funding, tied to this criteria.

Transitional areas are treated similar to the EMAs, except in two key areas. First, Transitional areas are not required to have formal planning councils, although they must have some process by which obtain community input to incorporate individuals as defined in Section 2602(b)(2) with one exception: "grandfathered" EMAs. EMAs are required to have planning councils for fiscal year 2007 through fiscal year 2009. The Committee opted to limit that requirement in recognition that, after three years, communities in similar situations should be similarly treated. Second, Transitional areas are not eligible for hold-harmless provisions.

The Committee focused its efforts on ensuring that the money followed the epidemic. Therefore, as funded cities move between the various tiers, the general rule is that the funding for those entities move with them (given the individuals with HIV/AIDS still need services in the area). Thus, the legislation builds in special rules to allow the funding to do so, while still recognizing that supplemental funding is not guaranteed funding.

If an EMA is no longer eligible for funding due to a decrease in the incidence and prevalence of AIDS cases, then the formula funding for that EMA would move to either the Transitional areas formula pool (if the EMA was then eligible as a Transitional area) or to the Part B base formula pool (if the EMA was then eligible as either an Emerging Community or not separately eligible for funding). Given that the supplemental funding is not guaranteed, the

supplemental funding is deemed to be $500,000 for each grantee, and that amount is likewise transferred. The Committee determined the $500,000 value by taking the average supplemental grant for the grandfathered EMAs in fiscal year 2006. That average was around $700,000. Therefore, $500,000 was deemed a reasonable estimate of the supplemental funds that should be transferred. However, given that the Part A entities share the supplemental pool, transfers of funding for the supplemental dollars are only allocated when an EMA either moves to an Emerging Community or no longer eligible for separate funding. In that situation, the supplemental funding deemed to be $500,000 is transferred to the Part B base funding.

If a Transitional area is deemed eligible as an EMA, then the formula funding would be transferred to the EMA formula pool.

C. PROVISIONS APPLICABLE TO PART B

In February 2006, the GAO released a report entitled "HIV/AIDS: Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Funds." The GAO highlighted that, "states with EMAs . . . receive more funding per ELC than states without EMAs because cases within EMAs are counted twice, once in connection with Title I base grants and once for Title II base grants. Eighty percent of Title II base grants is determined by the total number of ELCs in the state or territory. The remaining 20 percent is based on the number of ELCs in each jurisdiction outside the EMA." With this provision, States with no EMAs receive, on average, $3,592 per estimated living case (ELC), while States with more than 75 percent of their ELCs in EMAs receive $4,955 per ELC, or 33 percent more per case. In recognition of the issues resulting from this distribution pattern, the Committee took two actions.

First, the Committee recognized that the current system for allocating funds did not take into account variations in the relative needs of all individuals with HIV/AIDS within the State, including specific service needs (e.g., distance to care, cost to provide services, services provided through an EMA, etc.) and individual needs (e.g., insurance status, HIV or AIDS status, etc.). Therefore, the Committee required that the Secretary develop a severity of need index (SONI) to replace the "double-counting" or 80/20 provisions.

Due to the complexity of these issues coupled with the ongoing desire to have a more rational distribution of funds, the Committee further required that any new SONI not be in effect until fiscal year 2011, while requiring that SONI take effect no later than by fiscal year 2013. The Secretary must provide the new SONI by January 1 of the calendar year, along with additional required documentation, for it to go into effect by October 1, the beginning of the next fiscal year. This time frame is required so that Congress can do a careful consideration of the SONI, including examining information required to be submitted by the Secretary which includes the methodology and rationale (including field testing), expected change in funding allocations, process for community input, timeline and process for implementation, and independent contractor analysis. Further, to ensure that Congress is updated on the progress of the SONI, there is a requirement for annual reports for the SONI.

Second, as a short-term measure, until the SONI is used to allocate the Part B base formula more equitably, the Committee altered the double-counting or 80/20 provisions to shift more resources to States without funding under part A. Thus, the 80/20 provisions became 75/20/5, with 0.75 (reduced from 0.8) as the distribution factor for all cases in the State in which every State is eligible, 0.20 as a distribution factor for all cases outside of EMAs in a State in which every State is eligible, and 0.05 as a distribution factor for all cases outside Part A in a State, but only for States without any Part A funds.

The development of a valid SONI has been a work in progress, as evidenced by the efforts, authorized by the Ryan White Care Act of 2000, of the Institute of Medicine (IOM). In its report "Measuring What Matters" (2004), the IOM concluded at that time that insufficient accurate, universally available, unbiased data exist to create a reliable SONI. Subsequent work funded by HRSA has revisited existing datasets and analyses, and proposed selected elements that may constitute components of such an index, but also identified numerous areas of insufficient data and/or insufficient rationale for their inclusion in an index. It is notable that both the IOM and subsequent development processes were focused on the revision of indices to inform the allocation of Part A supplemental awards.

The Committee intends the Secretary to make selective use of existing research and analyses from these prior attempts, and to also identify, evaluate, individually and collectively analyze, and experimentally apply an array of indicators toward a defensible SONI meaningfully and without bias.

In addition, the Committee intends for the Secretary to engage an objective, independent contractor with broadly acknowledged impartiality and expertise to conduct future investigations into a new SONI.

With reference to Section 203(b)(3)(F)(v)(III), the Committee intends the Secretary to collect and apply current epidemiologic data from jurisdictions, to the degree that HIV/AIDS and other disease case report data are factored into the proposed index, for the purposes of testing the allocation impact of the index.

With reference to Section 203(b)(3)(F)(v)(IV), the Committee intends for the Secretary to allow the necessary time for community input, so as to allow sufficient time for analysis and commentary by interested parties.

The Committee further intends that any proposed SONI shall not provide incentives for jurisdictions to reduce their local resource contributions to HIV/AIDS care funded by the RWHATMA, including contributions made through State and local programs.

The ADAP drug lists vary significantly across the country, ranging from 19 drugs covered in Guam to nearly 500 in New York and open formularies in four jurisdictions—Massachusetts, New Hampshire, New Jersey, and the Northern Mariana Islands. While the majority of ADAPs (35) cover all 25 FDA-approved antiretrovirals on their formularies, 20 ADAPs do not, including one that does not provide any protease inhibitors (South Dakota). Forty-four ADAPs cover Fuzeon, the only approved fusion inhibitor for people with HIV/AIDS. The Committee is concerned that individuals eligible for the ADAP may not have access to core antiretroviral medications,

thereby reflecting current inequities in access to care. Therefore, the legislation requires ADAPs to include minimum core antiretroviral medications. It is the Committee's intent that the list merely establishes minimum coverage requirements for ADAPs; States may also include additional eligible treatments in their ADAPs. Although the Committee considered expanding that list to also include opportunistic infection medications, given the increased discussion about which drugs would be most appropriate on that list, the Committee opted only to focus on antiretrovirals at this time and hopes that subsequent reauthorizations will reexamine the need to potentially expand the list of core medications covered by ADAP. It is also the intent of the Committee that the Secretary will develop the list of core antiretroviral medications in consultation with the Public Health Service.

The Committee was further concerned to hear reports that States may not be reallocating drug rebate dollars back into the ADAP. Therefore, the Committee clarified that any drug rebates for drugs purchased through the ADAP should be applied to the ADAP.

To ensure that the ADAP supplemental funds were targeted toward the purchase of key medications for individuals with HIV/AIDS, the Committee opted to limit the overall ADAP supplemental activities to those involving the purchase of those key medications (either directly or through the purchase of health insurance). Therefore, unlike current law, the ADAP supplemental pool will no longer be the source of funding for the Part B hold-harmless. In addition, the ADAP supplemental pool is further enhanced by increasing the amount of the ADAP set aside of funds from three to five percent to fund the ADAP supplemental pool given the growing need for these funds.

In addition, the Committee clarifies that all territories are eligible for ADAP awards but does not alter the minimum amount that each territory may receive under Part B base grants.

The Committee was concerned to hear reports that the Secretary found it difficult to rapidly respond to emerging needs of particular populations. For instance, in 2003, when the Secretary determined through surveillance activities a cluster of HIV infection among African-American university students, the Secretary had no ability to quickly respond and provide additional services to deal with the increased HIV load in that area. In response to this situation, the Committee believed that it was important to have a small pool of funds available to the Secretary to deal with these emerging needs and not just the ADAP supplemental funds. Thus, the Committee created the Part B base supplemental pool, which is funded solely out of one-third of any increased funds provided to Part B base over what is provided in fiscal year 2006. The supplemental award is modeled after the Part A application, in that the criteria are identical, including the prioritization for States that meet the required criteria. Further, the Committee expects that a State will, under normal circumstances, be able to apply for these funds under the same application as the formula application. However, in limited circumstances, such as the case with the cluster of HIV cases, the Secretary may opt to accept supplemental applications throughout the year to address emerging needs.

The Committee opted to keep the second tier of the Emerging Communities program within Part B. In doing so, the Committee

clarified that the funds for the Emerging Communities program, although granted to the State, should be allocated to the Emerging Community.

The Committee intends that with respect to Section 209, only new CDC funding should be reallocated from the CDC appropriation to annually fund the early diagnosis grant program. If the amount available each year for these awards is not so awarded, it is the intent of the Committee that the funds would be available to be awarded for these grants in the following years in order to have the necessary funds available to provide awards to States as they become eligible to receive these awards. It is not the intent of the Committee that funds available but not awarded in any year during the reauthorization be returned to the Treasury.

Bringing pregnant women in for care and treatment is the essential link to reducing perinatal transmission. Thus, the Committee intends that States be allowed the flexibility to use their grant awards under this section to recruit pregnant women diagnosed with HIV into care, and provide necessary treatment and case management to prevent mother-to-child transmission of HIV.

D. PROVISIONS APPLICABLE TO PART C

The Committee believed as if it was important to further clarify that the purpose of the program under Part C is to provide services to underserved populations. Although the initial list of grantees would suggest this purpose, the Committee believed it important to explicitly clarify this point.

E. PROVISIONS APPLICABLE TO PART D

The Committee did not require that entities receiving funds under Part D spend 75 percent of their funds on core medical services, simply because the current Part D grantees serve more of a coordination role, rather than a health care services function.

The Committee believed it was important to limit the administrative expenses of Part D grantees. However, in defining what was included within administrative expenses, the Committee departed from standard definitions of the term, given the lack of standardized information on how those grantees are allocating and spending those funds. Thus, the Committee requested a more thorough GAO review of these activities to determine a more appropriate definition of administrative expenses. In providing this review, the GAO should examine qualitative and quantitative data that are not currently captured by Federal data systems. Therefore, the Committee is hopeful that during the next reauthorization, this term may be revisited, with the additional information obtained from the GAO report.

Part D provides a program of grants for coordinated, family-centered services. Part D grantees may engage in a broad range of activities to reduce mother-to-child transmission, including voluntary testing of pregnant women and treatment to reduce mother-to-child transmission. In addition, Part D grantees are required to provide individuals with information and education on opportunities to participate in HIV/AIDS clinical research. Part D is specifically charged with linking women, children, youth, and families living with HIV/AIDS to care, services, and research.

Women and young people—in particular, women and youth of ethnic and racial minorities—are an increasing portion of new HIV infections. The Committee is aware that with a specific focus on families, Part D grantees have taken the lead in reducing mother-to-child HIV transmission in the United States.

The Committee intends to clarify that the current focus of the Part D activities is on coordinated, family-centered care (not research), while still maintaining a strong link with the research community. The Committee further intends to clarify that the current focus within Part D grantees of recruiting and retaining youth in care should continue. The Committee intends that Part D grantees continue their coordination with organizations that assist youth with reducing and eliminating their risk of contracting and transmitting HIV, and conducting a range of social and support services including case-finding and outreach to identify HIV-infected youth and bring them into care.

F. PROVISIONS APPLICABLE TO PART E

In an effort to provide more clarity in the overall program design, the Committee opted to move many of the general provisions, which were included throughout the CARE Act into Part E, while eliminating programs which had never been funded or re-examined in the last two reauthorizations. Thus, Section 2681 was formerly Sections 2675; and 2684, 2678.

However, the Committee also significantly altered former sections, given the current structure of the program. For instance, the Committee deleted the audit requirements formerly under Section 2675A and instead inserted modified requirements under Section 2682. In addition, the Committee shifted the definitions from Section 2676 to Section 2687. In doing so, the Committee provided a more comprehensive definition of "family-centered care," defined the term "families with HIV/AIDS," "youth with HIV," and "co-occurring conditions"; clarified the distinction between HIV and AIDS and the treatment of the terms within the funding formulas; and deleted definitions which were no longer relevant (e.g., designated officer of emergency response employees, emergency, emergency response employee, employer of emergency response employees, and exposed).

In addition, the Committee added new requirements and clarifications under Part E. In particular, the Committee believed, after examining the effect of Hurricane Katrina on parts of the Gulf Coast, it was important to provide greater flexibility of the program after a public health emergency or the equivalent thereof. However, in providing that flexibility, the committee limited the amount of funds that could be shifted in that situation to five percent of the funds available under each of the Parts A and B base supplemental pools. Further, the Committee believed that it was important, given the reliance on names-based HIV and AIDS reporting, that it was clear that the Secretary does not receive any personally-identifiable information, as given the term in regulations promulgated under the Health Insurance Portability and Accountability Act of 1996. The Committee also added, in Section 2686, a biennial GAO report on HIV program integration, particularly for racial and ethnic minorities, including activities carried out under the codi-

fication of the Minority AIDS Initiative under subpart III of Part F.

G. PROVISIONS APPLICABLE TO PART F

Given the ongoing desire of the Committee to have client level data, the Committee opted to alter the Special Projects of National Significance (SPNS) to clarify that SPNS has two main goals—(1) funding special programs to develop standard electronic client information; and (2) quickly responding to emerging needs of individuals receiving assistance under the program.

Within the Minority AIDS Initiative, the Committee intends that funds are targeted to address the growing HIV/AIDS epidemic and its disproportionate impact upon communities of color, including African Americans, Latinos, Native Americans, Asian Americans, Native Hawaiians, and Pacific Islanders. Department statistics show that racial and ethnic minorities represent the highest number of new AIDS cases. While African-Americans and Hispanics are represented among roughly one-fourth of the total U.S. population, they account for nearly three-fourths of all new AIDS cases. More than 70 percent of people living with AIDS are racial and ethnic minorities, and HIV has become a leading cause of death for African Americans. Additionally, racial and ethnic minorities are now represented among the majority of new AIDS cases, as well as among Americans living with AIDS.

The Committee expects the Department to tailor the portion of the Ryan White programs that are funded under the Minority AIDS Initiative as tightly as possible in order to address the growing health problem and maximize the participation of minority community based organizations. Funds provided by the Minority AIDS Initiative are to supplement, not to supplant, any resources, activities, or efforts carried out in other parts of the legislation or other programs of the Department to ensure such services are culturally competent and linguistically appropriate.

The Committee expects applications submitted for emergency assistance and care grants under the Minority AIDS Initiative to contain a comprehensive plan to provide services to racial and ethnic minorities, with particular attention to individuals who know their HIV status and those who are most at risk. This plan shall include a determination of the need and use of funds; a detailed description of HIV-related services, to include the availability of such services; the size and demographic of racial and ethnic minority populations to be served; and the intent to serve individuals as described in Section 2602(b)(2)(M) of the Public Health Services Act.

The Committee expects emergency assistance funds to be provided for competitive, supplemental grants to improve HIV-related health outcomes among racial and ethnic minorities in HIV/AIDS-related access, care and treatment in communities where racial and ethnic minorities are underserved with respect to such services for HIV/AIDS care and treatment; and bring racial and ethnic minorities into HIV/AIDS care and treatment.

The Committee also expects care grant funds to be provided for State HIV care grants to support educational and outreach services to increase the number of eligible minorities who access HIV/AIDS treatment through ADAP. The Committee strongly urges States to

maximize the participation of minority community-based organizations in delivering these educational and outreach services.

The Committee intends that early intervention services funds be provided for planning grants and Early Intervention Service (EIS) grants to healthcare providers with a history of serving communities of color. The Committee strongly urges the Department to maximize the participation of minority community based organizations as defined above in planning and delivering EIS. Funds should also be made available to regional and local technical assistance organizations to assist service providers in identifying and increasing the retention of minorities in care with an emphasis on women of color and men of color who have sex with men (MSM) in highly impacted and underserved areas. Within the increase provided, the Department is urged to make enhancing the service capacity of existing minority EIS providers a priority.

As part of the Minority AIDS Initiative, the Committee expects that education and training centers funds are provided to increase the training capacity of AETCs to expand the number of community-based minority healthcare professionals with treatment expertise and knowledge about the most appropriate standards of HIV/AIDS-related treatments and medical care for HIV infected adults, adolescents, and children as developed by the U.S. Public Health Service. The training of minority providers as part of the Minority AIDS Initiative is to be implemented through collaborations with Historically Black Colleges and Universities (HBCU), Hispanic Serving Institutions, and Tribal Colleges. These efforts are designed to increase the treatment expertise and HIV knowledge of minority front-line providers serving individuals living with HIV/AIDS. Funds are also intended to support minority community based organizations to train minority providers to deliver culturally competent and linguistically appropriate treatment education services.

H. PROVISIONS APPLICABLE TO TITLE 7

Most of the approximately five million Americans infected with the hepatitis C virus (HCV) are unaware they have a transmissible and potentially deadly disease, precluding them from initiating treatment and implementing behavioral changes that can save their lives.

The CDC estimates about 25 percent of Americans with HIV/AIDS are co-infected with HCV. End-stage liver disease secondary to chronic hepatitis C infection is now the leading cause of death among people with HIV/AIDS in the United States.

Despite the high rate of mortality due to hepatitis C among people with HIV/AIDS, only a handful of traditional AIDS service providers, including a few CARE Act grantees, have begun to address this critical issue. This issue is particularly problematic in large urban areas where the majority of HCV/HIV co-infected patients live and receive services.

The main problem is that this is not just a matter of ADAP providing HCV drugs for co-infected patients, it relates to all medical and social service providers recognizing the impact of HCV on persons with HIV, getting the proper training to help these individuals, and integrating the appropriate services into their programs.

Part A grantees contracted with over 1,500 agencies to offer social support and medical care services to over 800,000 patients in 2003. The majority of patients served under Part A are racial and ethnic minorities, African Americans, in particular, who are disproportionately impacted by both HIV and HCV. Part A providers, as do providers funded under other parts require the guidance, expertise and resources to adequately serve their HCV/HIV co-infected patients.

Some studies have reported that people with co-infection have higher levels of hepatitis virus in their blood, more rapid progression of liver damage, and a greater rate of death due to hepatitis than people with only HCV infection. Other recent research found no correlation between HCV progression and HIV status. Hepatitis B (HBV) is the most common viral hepatitis infection in people with HIV. Given this information about HCV and HBV, the Committee took a variety of actions throughout the legislation to acknowledge these issues.

BACKGROUND AND NEED FOR LEGISLATION

In March 1990, Congress enacted the Ryan White CARE Act (CARE ACT), honoring Ryan White, a young man who taught the Nation to respond to the HIV/AIDS epidemic with hope and action rather than with fear. By spring 1990, over 128,000 people had been diagnosed with AIDS in the United States; 78,000 had died of the disease. The CARE Act was reauthorized in 1996 and 2000, in recognition of the fact that the epidemic continued to spread and that primary care and support services provided through the Act were still vitally important to people with HIV and AIDS and the healthcare systems in their communities.

Today, more than 944,306 cases of AIDS have been reported to the CDC. More than 529,113 men, women, and children have died as the epidemic has spread over the last 25 years, to both new populations and new geographic areas. The epidemic continues to grow, touching larger numbers of people and more segments of our society. The heterosexual transmission rate continues to increase; women and minorities are increasingly being affected. Rural areas of the country are now feeling the full impact of the epidemic. Those areas must now confront the same social, economic, and personal challenges that the original urban epicenters have been facing since 1981.

The continued expansion of the AIDS epidemic in America is a certainty. Yet, diagnosed AIDS cases measure only a portion of the problem. The CDC estimates that there are between 1,039,000 and 1,185,000 people currently living with HIV in the United States, with 40,000 new infections annually. In addition to new infections and persons living with HIV infection who are not in care, individuals in treatment are living longer with the disease, increasing demands on the healthcare system. Hundreds of thousands of these Americans will require healthcare services for HIV-related conditions in the future. This will continue to challenge the Nation's healthcare system.

While a cure for HIV has eluded scientists, science has made significant progress in developing treatments for HIV. Therapies now exist that, for many people, can help slow the progression of HIV and allow the immune system to recover some of its ability to resist

opportunistic infections associated with AIDS. These therapies have drastically reduced the number of deaths from AIDS and the number of new AIDS cases over the last four years. In addition, prenatal administration of Zidovudine (also known as AZT) along with active outreach to and counseling of pregnant women have nearly eliminated the perinatal transmission of HIV. These developments have resulted in longer survival rates for people diagnosed with AIDS and have highlighted the importance of and need for early intervention and early treatment.

Public policy must follow the expanding epidemic and incorporate the advances in scientific and medical information regarding HIV. Effective policy should also address the increasing service needs that the epidemic creates and integrate the advances in knowledge, understanding, and treatment of the disease. With the introduction of potent antiretroviral therapies, for example, patient demand for financial assistance has increased rapidly, precipitating a financial crisis in AIDS drug assistance programs across the country. As the epidemic, the affected communities and populations, and the medical response continue to change, public policy must be flexible enough to meet unexpected challenges.

The Ryan White CARE Act originally responded to the need for HIV primary care and support services. The major focus of public policy prior to the CARE Act was on research, public education, surveillance, and prevention. These activities are still a necessary priority and continue to receive attention and funding through the National Institutes of Health and the CDC. In contrast, the CARE Act has helped people with HIV/AIDS to obtain primary care and support services to save and improve their lives. The CARE Act has played a critical role in the Nation's response to the AIDS epidemic.

The public health burden and the economic burden of the AIDS epidemic have not been reduced since the CARE Act was passed. While the CARE Act has been a lifeline of support to many people, the continued need for services grows faster than the resources available. In fact, the steady expansion and changed demographics of the epidemic and the increasing survival rates for people living with HIV/AIDS have increased the stress on local healthcare systems in some areas. This strain is believed both in urban centers where the epidemic continues to rage, and in smaller cities and rural areas, where the epidemic is expanding rapidly.

The Ryan White CARE Act Amendments of 2000 preserved and improved upon the best aspects of the original CARE Act. At the same time, in recognition of the changes that have taken place over the last five years, the Committee has also made some necessary alterations. To address the geographic expansion of this epidemic, this reauthorization continues the efforts made during the last reauthorization to direct resources and services to areas that are particularly underserved, including rural areas and metropolitan areas with significant HIV and AIDS cases that are not eligible for Part A funding. There is also a new focus on strengthening the capacity of rural and minority communities to address the epidemic. Furthermore, ADAP has been strengthened to assist States that are struggling to provide medications to all of their needy clients. The Committee has also sought to strengthen the ability of local communities, States, and service organizations to reach those commu-

nities and populations that have been historically most underserved, as well as those that are experiencing rapid increases in HIV infection and AIDS case counts but that have not been brought into the care system developed under the Ryan White program. The purpose of these changes is to ensure a strong system of health care delivery and access to therapies commensurate with evolving needs.

HEARINGS

The Subcommittee on Health held a hearing on Reauthorizing the Ryan White CARE Act: How to Improve the Program to Ensure Access to Care on April 27, 2006. The Subcommittee received testimony from: Elizabeth Duke, Ph.D., Administrator, Health Resources and Services Administration, U.S. Department of Health and Human Services; Kevin Fenton, MD, Ph.D., Director, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; and Marcia Crosse, Ph.D., Director, Health Care Group, Government Accountability Office.

COMMITTEE CONSIDERATION

On Wednesday, September 20, 2006, the Full Committee met in open markup session and ordered a Committee Print entitled the Ryan White HIV/AIDS Treatment Modernization Act of 2006 favorably reported to the House, amended, by a record vote of 38 yeas and 10 nays, a quorum being present. A request by Mr. Barton to allow a report to be filed on a bill to be introduced, and that the actions of the Committee be deemed as actions on that bill, was agreed to by unanimous consent.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following are the recorded votes taken on amendments offered to the measure, including the names of those Members voting for and against. A motion by Mr. Barton to order the Committee Print entitled the Ryan White HIV/AIDS Treatment Modernization Act of 2006 favorably reported to the House, amended, was agreed to by a record vote of 38 yeas and 10 nays.

COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 144

Bill: Committee Print, the Ryan White HIV/AIDS Treatment Modernization Act of 2006

AMENDMENT: An amendment by Mr. Towns, No. 1, to provide a five year hold harmless for formula funding for Parts A and B grantees and increase the authorizations overall for Parts A and B for each of the fiscal years 2007-2011.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 21 yeas to 22 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman			
Mr. Bilirakis		X		Mr. Markey	X		
Mr. Upton				Mr. Boucher			
Mr. Stearns				Mr. Towns	X		
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Deal		X		Mr. Brown			
Mr. Whitfield		X		Mr. Gordon			
Mr. Norwood		X		Mr. Rush	X		
Ms. Cubin				Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Stupak	X		
Ms. Wilson				Mr. Engel	X		
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering		X		Mr. Green	X		
Mr. Fossella		X		Mr. Strickland			
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer		X		Ms. Capps	X		
Mr. Radanovich				Mr. Doyle	X		
Mr. Bass		X		Mr. Allen			
Mr. Pitts		X		Mr. Davis			
Ms. Bono	X			Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis	X		
Mr. Terry		X		Mr. Gonzalez	X		
Mr. Ferguson	X			Mr. Inslee	X		
Mr. Rogers				Ms. Baldwin	X		
Mr. Otter		X		Mr. Ross	X		
Ms. Myrick		X					
Mr. Sullivan		X					
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn		X					

9/20/2006

COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 145

Bill: Committee Print, the Ryan White HIV/AIDS Treatment Modernization Act of 2006

AMENDMENT: An amendment by Mr. Pallone, No. 3, to (1) provide for a one-year extension and increase in authorizations for fiscal year 2007; (2) provide $30,000,000 for grants to States that demonstrate unmet need and that do not have any Part A eligible areas receiving grants, and to make the funds available until the end of fiscal year 2009; and (3) prohibit the Secretary from using a methodology for counting the number of cases acquired immune deficiency syndrome, or the number of cases of HIV, that is different that the methodology that was used for such purposes in fiscal year 2006, for purposes of funding distributions in fiscal year 2007.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 21 yeas to 23 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman	X		
Mr. Bilirakis		X		Mr. Markey	X		
Mr. Upton		X		Mr. Boucher			
Mr. Stearns				Mr. Towns	X		
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Deal		X		Mr. Brown			
Mr. Whitfield				Mr. Gordon			
Mr. Norwood		X		Mr. Rush	X		
Ms. Cubin				Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Stupak	X		
Ms. Wilson				Mr. Engel	X		
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering		X		Mr. Green	X		
Mr. Fossella		X		Mr. Strickland			
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer				Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle	X		
Mr. Bass		X		Mr. Allen			
Mr. Pitts		X		Mr. Davis			
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis	X		
Mr. Terry		X		Mr. Gonzalez	X		
Mr. Ferguson	X			Mr. Inslee	X		
Mr. Rogers				Ms. Baldwin	X		
Mr. Otter		X		Mr. Ross	X		
Ms. Myrick		X					
Mr. Sullivan		X					
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn		X					

9/20/2006

COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 146

Bill: Committee Print, the Ryan White HIV/AIDS Treatment Modernization Act of 2006

MOTION: A motion by Mr. Barton to order the committee print reported, as amended.

DISPOSITION: **AGREED TO**, by a roll call vote of 38 yeas to 10 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton	X			Mr. Dingell	X		
Mr. Hall	X			Mr. Waxman		X	
Mr. Bilirakis	X			Mr. Markey		X	
Mr. Upton	X			Mr. Boucher			
Mr. Stearns	X			Mr. Towns		X	
Mr. Gillmor	X			Mr. Pallone		X	
Mr. Deal	X			Mr. Brown			
Mr. Whitfield	X			Mr. Gordon			
Mr. Norwood	X			Mr. Rush	X		
Ms. Cubin				Ms. Eshoo		X	
Mr. Shimkus	X			Mr. Stupak	X		
Ms. Wilson				Mr. Engel		X	
Mr. Shadegg	X			Mr. Wynn	X		
Mr. Pickering	X			Mr. Green	X		
Mr. Fossella		X		Mr. Strickland			
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer	X			Ms. Capps		X	
Mr. Radanovich	X			Mr. Doyle	X		
Mr. Bass	X			Mr. Allen			
Mr. Pitts	X			Mr. Davis			
Ms. Bono	X			Ms. Schakowsky	X		
Mr. Walden	X			Ms. Solis		X	
Mr. Terry	X			Mr. Gonzalez	X		
Mr. Ferguson		X		Mr. Inslee	X		
Mr. Rogers	X			Ms. Baldwin	X		
Mr. Otter	X			Mr. Ross	X		
Ms. Myrick	X						
Mr. Sullivan	X						
Mr. Murphy	X						
Mr. Burgess	X						
Ms. Blackburn	X						

9/20/2006

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held a legislative an oversight hearing and made findings that are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The goal of the Ryan White HIV/AIDS Treatment Modernization Act is to address the unmet care and treatment needs of persons living with HIV/AIDS by funding primary health care and support services that enhance access to and retention in care.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 6143, Ryan White HIV/AIDS Treatment Modernization Act of 2006, would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

EARMARK

In compliance with H. Res. 1000 as passed the House of Representatives on September 14, 2006, the Committee finds that H.R. 6143, Ryan White HIV/AIDS Treatment Modernization Act of 2006, contains no earmarks.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

SEPTEMBER 27, 2006.

Hon. JOE BARTON,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 6143, the Ryan White HIV/AIDS Treatment Modernization Act of 2006.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Camile Williams.

Sincerely,

DONALD B. MARRON,
Acting Director.

Enclosure.

H.R. 6143—Ryan White HIV/AIDS Treatment Modernization Act of 2006

Summary: H.R. 6143 would reauthorize the Ryan White program in title XXVI of the Public Health Service Act. The Ryan White program provides grants to fund medical care and other support services for individuals with HIV/AIDS. The bill would modify certain provisions while maintaining the overall structure of the existing program.

H.R. 6143 would authorize the appropriation of about $2.3 billion for fiscal year 2007 and $12.2 billion over the 2007–2011 period. Although authorization for the Ryan White program expired in fiscal year 2005, about $2 billion was appropriated for the program for fiscal year 2006. Assuming the appropriation of the specified amounts, CBO estimates that implementing H.R. 6143 would cost $501 million in fiscal year 2007 and $9.6 billion over the 2007–2011 period. Enacting the bill would not affect direct spending or revenues.

H.R. 6143 contains no private-sector or intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 6143 is shown in Table 1. The costs of this legislation fall within budget function 550 (health).

TABLE 1.—BUDGETARY IMPACT OF H.R. 6143

	By fiscal year, in millions of dollars—					
	2006	2007	2008	2009	2010	2011
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law for the Ryan White Program:						
Budget Authority [1]	2,038	0	0	0	0	0
Estimated Outlays	1,523	1,324	271	41	0	0
Proposed Changes:						
Estimated Authorization Level	0	2,279	2,357	2,438	2,523	2,610
Estimated Outlays	0	501	1,931	2,271	2,395	2,478
Spending Under H.R. 6143 for the Ryan White Program:						
Estimated Authorization Level [1]	2,038	2,279	2,357	2,438	2,523	2,610
Estimated Outlays	1,523	1,825	2,202	2,312	2,395	2,478

[1] The 2006 level is the amount appropriated for that year for the Ryan White program.

Basis of estimate: H.R. 6143 would authorize appropriations for the Ryan White program for fiscal years 2007 through 2011. The Health Resources and Services Administration (HRSA) under the Department of Health and Human Services (HHS) administers most of the Ryan White program and works with the Centers for Disease Control and Prevention (CDC) and other federal health programs to plan and implement federal HIV/AIDS programs.

Table 2 shows the authorization levels specified in the bill. Assuming the appropriation of the specified amounts, CBO estimates that implementing the bill would cost $501 million in fiscal year 2007 and $9.6 billion over the 2007–2011 period. For the purposes of this estimate, CBO assumes the bill will be enacted near the beginning of fiscal year 2007 and that outlays will follow historical spending rates for the Ryan White program.

TABLE 2.—AUTHORIZATIONS OF APPROPRIATIONS IN H.R. 6143

	By fiscal year, in millions of dollars—				
	2007	2008	2009	2010	2011
Title I (grants to local governments)	604	626	650	674	699
Title II (grants to states)	1,206	1,250	1,295	1,343	1,392
Title III (early intervention services)	219	227	235	244	253
Title IV (women, infants, and children)	72	72	72	72	72
Title V (general provisions) [1]	.....	.....	.....	.....	.....
Title VI (demonstration and training)	179	183	187	191	195
Total Proposed Changes	2,279	2,357	2,438	2,523	2,610

[1] The bill does not specify any authorization levels for title V. CBO estimates that changes to the funding required for activities under that title would be negligible.

Grants to local governments: Title I of the H.R. 6143 would modify and authorize provisions in prior law that directed the Secretary of Health and Human Services to make two types of grants to local governments. Formula grants would be awarded to governments in metropolitan areas with a population of at least 50,000 and at least 500 AIDS cases. Those grants would be allocated based on the number of people living with HIV or AIDS. The Secretary would award supplemental grants after determining that an applicant had demonstrated need for AIDS-related services.

For title I grants, the bill would authorize the appropriation of $604 million for fiscal year 2007 and $3.3 billion over the 2007–2011 period. Assuming the appropriation of the specified amounts, and based on historical spending patterns for the program, CBO estimates that implementing title I would cost $133 million in fiscal year 2007 and $2.5 billion over the 2007–2011 period.

Counting HIV/AIDS Cases. Under the prior authorization for the Ryan White program, the formula grants were allocated based on the number of AIDS cases. The bill would modify the allocation formula to include both HIV cases and AIDS cases. H.R. 6143 also would apply a uniform national adjustment factor in jurisdictions where the reporting system does not produce an unduplicated count of HIV/AIDS cases.

Cap on Core Medical Services. The bill would require grantees to spend at least 75 percent of grant funds on primary care services and other core medical services. The remaining funds could be used for support services needed to achieve medical outcomes. That requirement could be waived if the grantees' service area does not have a waiting list for the AIDS Drug Assistance Program (ADAP) and core medical services are available to all individuals with HIV/AIDS.

Hold-Harmless Provision. H.R. 6143 would establish a hold-harmless mechanism for grantees that received a formula grant for 2006. If the specified amounts are not appropriated for fiscal years 2007 through 2009, the bill would require the Secretary to reduce funding for supplemental grants, if necessary, to maintain formula grants at 95 percent of the amount awarded in the previous year.

Unobligated Balances. The bill would require the recipients of supplemental grants to return any unobligated balances to the Secretary at the end of the grant year. It also would require the recipients of formula grants to return unobligated balances at the end of a grant year unless the recipient submits a plan to spend those balances in the coming year. Funds that remain unexpended for

two years must be returned. The Secretary would redistribute the returned funds as supplemental grants.

Grants to states: Title II would modify provisions in prior law that directed the Secretary to make grants to states and territories for medical and support services that are delivered primarily through consortia of providers. States also would be required to use some of their grant funds to pay for drug treatment through ADAP.

The bill would authorize the appropriation for those grants to states of $1.2 billion for fiscal year 2007 and $6.5 billion over the 2007–2011 period. Assuming the appropriation of the specified amounts, and based on historical spending patterns for the program, CBO estimates that implementing title II would cost $265 million in fiscal year 2007 and $5.1 billion over the 2007–2011 period.

ADAP Minimum Drug List. H.R. 6143 would require the Secretary to develop a list of core antiretroviral therapeutics to ensure the inclusion of those drugs on the ADAP formulary. States could also include other drugs on that formulary. In addition, the bill would require that rebates for drugs purchased with Ryan White funds be used for activities under ADAP.

Early Diagnosis Grant Program. The bill would authorize CDC to make grants to eligible states to pay for certain services including HIV/AIDS testing, prevention counseling, and treatment of newborns exposed to HIV/AIDS or mothers infected with HIV/AIDS. To be eligible for those grants, a state must have qualifying early diagnosis program—either voluntary testing of pregnant women with universal testing of newborns, or voluntary testing of clients at clinics for sexually-transmitted diseases and at substance-abuse centers.

Early intervention systems: Title III would authorize HRSA to make grants to public and nonprofit entities to pay for community-based programs that provide comprehensive primary-care services aimed at preventing or reducing HIV-related morbidity. The bill would require grantees to provide counseling and information about hepatitis A, B, and C. It also would require grantees to develop an electronic information system to improve the grantee's ability to report client-level data.

For those grants, the bill would authorize the appropriation of $219 million for fiscal year 2007 and $1.2 billion over the 2007–2011 period. Assuming the appropriation of the specified amounts, and based on historical spending patterns for the program, CBO estimates that implementing title III would cost $48 million in fiscal year 2007 and $923 million over the 2007–2011 period.

Women, infants, and children: Title IV would authorize HRSA to make grants to public and nonprofit entities to improve and expand primary care and support services for women, infants, or children with HIV/AIDS and for their families.

For those grants, the bill would authorize the appropriation of $72 million for fiscal year 2007 and $359 million over the 2007–2011 period. Assuming the appropriation of the specified amounts, and based on historical spending patterns for the program, CBO estimates that implementing title IV would cost $16 million in fiscal year 2007 and $286 million over the 2007–2011 period.

General provisions: Title V would require coordination among federal HIV programs concerning planning, funding, and imple-

mentation plans. Those federal programs include HRSA, CDC, the Substance Abuse and Mental Health Services Administration, and the Centers for Medicare and Medicaid Services. CBO estimates the costs of such activities would be negligible.

Demonstration and training programs: Title VI would authorize HRSA to make grants to certain schools and centers that conduct HIV/AIDS education and training programs for healthcare providers. The bill also would require an evaluation to address the disproportionate impact of HIV/AIDS and disparities in access, treatment, care, and outcomes for racial and ethnic minorities. In addition, the bill would authorize grants to support the development of information technology to report client-level data and help respond to emerging needs of populations served by the Ryan White program.

For those grants, the bill would authorize the appropriation of $179 million for fiscal year 2007 and $935 million over the 2007–2011 period. Assuming the appropriation of the specified amounts, and based on historical spending patterns for the program, CBO estimates that implementing title VI would cost $39 million in fiscal year 2007 and $737 million over the 2007–2011 period.

Intergovernmental and private-sector impact: H.R. 6143 contains no private-sector or intergovernmental mandates as defined in UMRA. The bill would alter some grant conditions related to funding of HIV/AIDS programs, in some cases placing new requirements on grant recipients, and in other cases affording such recipients greater flexibility in the use of these funds. Any costs associated with complying with new grant conditions would be incurred voluntarily.

Estimate prepared by: Federal costs: Camile Williams; Impact on State, local, and tribal governments: Leo Lex; Impact on the private sector: Noelia Duchovny.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or

accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title: Table of contents

Section 1 establishes the short title of the Act as the "Ryan White HIV/AIDS Treatment Modernization Act of 2006," and contains the table of contents.

TITLE I—EMERGENCY RELIEF FOR ELIGIBLE AREAS

Section 101. Establishment of program; general eligibility for grants

Section 101 maintains the current initial eligibility threshold to qualify as an eligible metropolitan area (EMA)—metropolitan areas (defined as 50,000 or more people) with 2,000 or more cumulative AIDS cases reported to the Centers for Disease Control and Prevention (CDC) in the last five years. Eligibility is maintained until a grantee falls below the eligibility threshold and below an overall prevalence test (3,000 living AIDS cases) in a given year for three consecutive years at which time the EMA would move down to the appropriate tier or out of Part A funding eligibility.

Boundaries for currently funded metropolitan areas remain as those that applied to the metropolitan area in 1994. Boundaries for new metropolitan areas would be determined at time of entry. Eligibility for new metropolitan areas shall be determined on an annual basis, as per 2607(2).

Section 102. Type and distribution of grants; formula grants

Section 102 changes the formula distribution from 50 percent to 66 2/3 percent. The funds are distributed by formula based on living names-based HIV (not AIDS) and living names-based AIDS case counts. The following jurisdictions must use their names-based HIV and names-based AIDS case counts for purposes of determining their formula funding: Alaska, Alabama, Arkansas, Arizona, Colorado, Florida, Indiana, Iowa, Idaho, Kansas, Louisiana, Michigan, Minnesota, Missouri, Mississippi, North Carolina, North Dakota, Nebraska, New Jersey, New Mexico, New York, Nevada, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, West Virginia, and Wyoming.

There is a four-year exemption (fiscal years 2007 through 2010) from the required use of names-based HIV (not AIDS) and living names-based AIDS case counts for all other States, if certain conditions are met. These code-based jurisdictions may use their reported code-based counts of living HIV (not AIDS), adjusted by the national duplication rate of five percent, in lieu of the names-based HIV counts, if: (1) the State will by October 1, 2006, have submitted a transition plan for reporting names-based HIV counts (as accepted by the Director of CDC) or (2) not later than October 1, 2006, the State will have made all necessary statutory changes to allow for the collection of names-based HIV data (as accepted by the Director of CDC); and by April 1, 2008, begin reporting names-based HIV counts (as determined by the Director of CDC). This exemption is not available for formula distribution for fiscal year 2011 or any subsequent fiscal year since all funding will be based on names-based living HIV (not AIDS) and living AIDS cases. In

addition, a code-based State may not receive more than a five percent increase over the preceding fiscal year.

For Part A entities that cross State boundaries, the cases for each State will be treated as per the status for that State. For example, the District of Columbia EMA, which crosses the District of Columbia, Maryland, and Virginia, and the cases within the District of Columbia and Maryland would be treated under the exemption, while the names-based cases for Virginia would be counted.

The Secretary will reexamine the readiness of a State to switch from exemption status to counting only names-based counts on an annual basis. This determination must be made by the beginning of the fiscal year in consultation with the chief executive of the State in which the area is located. The Secretary will carry out a program to monitor the reporting of names-based cases and to detect instances of inaccurate reporting, including fraudulent reporting.

Section 102 also changes the hold-harmless provisions under current law. Under section 102, hold-harmless would apply to all EMAs for fiscal years 2007 through 2009 at 95 percent of the formula amount of the previous fiscal year. The hold-harmless will not be applicable after 2009. In allocating funds for the hold-harmless provisions, the funding will first come from the Part A supplemental grant pool. Once the funds from the Part A supplemental grant pool are exhausted, then there will be a pro rata reduction across all EMAs.

Section 103. Type and distribution of grants; supplemental grants

Section 103 changes the criteria for awarding Part A supplemental grants. All references to "severe need" in current law are changed to "demonstrated need." Factors of demonstrated need may include: (1) unmet need for such services, as determined under Section 2602(b)(4) or other community input process as defined under Section 2609(d)(1)(A); (2) an increasing need for HIV/AIDS-related services, including relative rates of increase in the number of HIV/AIDS; (3) the relative rates of increase in the number of cases of HIV/AIDS within new or emerging subpopulations; (4) the current prevalence of HIV/AIDS; (5) relevant factors related to the cost and complexity of delivering health care to individuals with HIV/AIDS in the eligible area; (6) the impact of co-morbid factors, including co-occurring conditions, determined relevant by the Secretary; (7) the prevalence of homelessness; (8) the prevalence of individuals who were Federal, State, or local prisoners and released from the custody of the penal system during the preceding three years with HIV disease as of the date of release; (9) the relevant factors that limit access to health care, including geographic variation, adequacy of health insurance coverage, and language barriers; and (10) the impact of a decline in the amount received under the formula grant on services available to all individuals with HIV/AIDS identified and eligible under the title.

In making the supplemental grant awards, the Secretary shall give priority to the area to address the decline in services related to the decline in the amounts received in the formula grant consistent with the grant award for the eligible area for fiscal year 2006, to the extent that factor (10) above relating to a decline in funding applies to the eligible area.

Grantees must also demonstrate the ability to expend funds efficiently by not having had more than two percent of grant funds under such subsection canceled or covered by any waivers for the most recent grant year.

Section 104. Timeframe for obligation and expenditure of grant funds

Section 104 provides the timeframe for obligation and expenditure of grant funds. The obligation of funds must be made by the end of the grant year. The Secretary shall cancel any unobligated supplemental funds at the end of the grant year and the returned funds shall be made available by the Secretary as additional amounts for grants. Any eligible area that has unobligated formula funds is required to return the funds to the Secretary or submit a waiver application describing how they intend to use the funds in the succeeding grant year. If the funds are not expended in the following grant year they will be returned to the Secretary and redistributed as supplemental grants. The Secretary may adjust the grant amount to reflect the amount of unexpended and uncanceled grant funds that remain at the end of a fiscal year above two percent of the formula grant award.

Section 105. Use of amounts

Section 105 sets forth the requirements for how eligible areas must use funds. Funds provided under this section may be expended only for core medical services, support services, and administrative expenses. Not less than 75 percent of funds must be spent on the defined core medical services. The remaining 25 percent, subject to the approval of the Secretary, may be used for support services (not defined) needed to achieve medical outcomes (therein "75/25 requirement"). Medical outcome is defined as those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS. The 75/25 requirement shall be waived by the Secretary if, in the grantee's service area: (1) there are not waiting lists for the AIDS Drug Assistance Program (ADAP) services; and (2) core medical services are available to all individuals with HIV/AIDS. However, if the requirement is thereby waived, the funds are still subject to the approval of the Secretary and must be needed to achieve medical outcomes. A grantee may not spend more that 10 percent on administrative costs (includes activities carried out by planning councils), which is applied before the 75/25 requirement.

The section also specifies that not less than the percentage based on the ratio of Women, Infants, Children, and Youth with HIV/AIDS to the general population of HIV/AIDS should be given for each grant made unless an area can demonstrate that the population involved is receiving HIV-related health services through the State Medicaid program, the State Children's Health Insurance Program, or other Federal or State programs. The section also maintains the current law provisions regarding funds used for clinical quality management programs. These funds may be applied before the 75/25 requirement.

Section 106. Additional amendments to Part A

Section 106 provides additional amendments to Part A. It requires that planning councils include representation from members

of a federally recognized Indian tribe and individuals with hepatitis B or C co-infection, when appropriate. It exempts the Indian Health Service from the payer of last resort provision. It requires that the chief elected official, responsible for the Part A grant, submit to the lead State agency audits regarding its expended funds every two years. In addition, the section provides for better coordination. As part of the grant application, a grantee will: (1) need to provide a narrative about how the activities are coordinated with the State and other grantees within that State; and (2) specify how the expenditures under the grant will improve overall outcomes (as outlined by the State) or through additional outcome measures.

Section 107. New program in Part A; Transitional grants for certain areas ineligible under section 2601

Section 107 establishes a new eligible entity for Part A funds—Transitional areas. These entities are eligible to receive Part A Transitional area funds if there are 1,000–1999 cumulative AIDS cases in a metropolitan area (50,000 or more people) reported in the last five years. Grandfathered EMAs are automatically classified as Transitional areas for fiscal year 2007. Eligibility is maintained until a grantee falls below the eligibility threshold and below an overall prevalence test (1,500 living AIDS cases) for three consecutive years at which time it would no longer be eligible for Part A funding. Eligibility to become an EMA or new Transitional area in Part A is determined on an annual basis. Formula funding and $500,000 from the supplemental grant pool moves with the grantee into the Part B base formula pool if the grantee no longer qualifies as a Part A eligible area. If the Transitional area becomes eligible for EMA funding under Part A, the formula funding follows the areas into the EMA formula funding pool. Boundaries are defined as the boundaries established for the Transitional area at the time of initial funding under Ryan White for new grantees under Part A. For entities that received funding previously from Part A, the boundaries are as they were in 1994.

Planning councils are voluntary, except for "grandfathered" EMAs for fiscal years 2007 through 2009. After fiscal year 2009, the chief elected official can opt not to have a planning council, but must demonstrate that he/she consulted with individuals with HIV in formulating the overall plan for spending the funding.

Hold-harmless provisions for EMAs under Part A do not apply for Transitional areas. One-third of all Part A funds (EMA and Transitional areas) will be pooled together for supplemental funding and two-thirds will be distributed by formula. The same provision under Section 104 regarding the timeframe for obligation and expenditure of grant funds applies to Transitional areas.

Section 108. Authorization of appropriations for Part A

Section 108 authorizes a 3.7 percent increase in authorization levels for each of fiscal years 2008–2011. Fiscal year 2007 is the base year. As described in Sections 101 and 107, if an eligible area falls from EMA to Transitional area status, its formula funding moves with it to the formula funding pool for Transitional areas. If an eligible area moves between Part A and Part B, then its formula funding and $500,000 from the Part A supplemental grant

pool would move from the Part A supplemental grant pool into the Part B base formula funding.

TITLE II—CARE GRANTS

Section 201. General use of grants

Section 201 includes the same 75/25 requirement for core medical services for States receiving Part B grants as section 105 for Part A grants. Additionally, expenditures of grants for or through consortia are deemed to be support services, not core medical services. Section 201 also includes the same requirement that a grantee may not spend more that 10 percent on administrative costs (includes activities carried out by planning councils), which is applied before the 75/25 requirement. This section also includes the same provisions regarding priority for women, infants, children, and youth with HIV/AIDS and use of funds for clinical quality management programs.

Section 202. AIDS Drug Assistance Program

Section 202 establishes a minimum drug list that includes the classes of drugs under the Public Health Service guidelines for core antiretroviral (ARV) therapeutics. It ensures that rebates for drugs purchased with Ryan White funds must be redirected to activities under the program.

Section 203. Distribution of funds

Section 203 changes the current funding distribution as follows: for fiscal years 2007 through 2011, 0.75 instead of 0.80 is calculated for all of the HIV/AIDS cases in the State; 0.20 is calculated based on all of the HIV/AIDS cases that are not counted for purposes of receiving Part A funds, and 0.05 is calculated for all of the HIV/AIDS cases for States not receiving any Part A funds (therein the "75–20–5 distribution factor").

The same requirements for counting names-based HIV and AIDS case counts, including exemptions from the requirements that were set forth in Section 102 apply to the distribution of formula funds under this section. Code-based States' gains are capped at 5 percent over the previous fiscal year.

This section provides movement towards collection of client-level data and the creation of a Severity of Need Index (SONI). If, by January 1, 2010, the Secretary notifies appropriate committees of Congress that a new SONI is ready, 75–20–5 distribution factor is eliminated and the new SONI will be used for formula allocations in fiscal year 2011, subject to the Congressional Review Act. The Secretary shall notify the appropriate committee of Congress that the Secretary has developed a SONI by January 1, 2012, and the SONI will replace the 75–20–5 funding distribution factor for fiscal year 2013, subject to the Congressional Review Act. The Secretary must provide the following information regarding the methodology and rationale behind developing the SONI and an independent contractor analysis this, as well as expected changes in funding allocations, information regarding community input and the timeline and process for implementation. This section requires annual reports from the Health Resources and Services Administration (HRSA)

about their progress toward obtaining client level data and developing SONI.

This section also increases the ADAP supplemental fund pool from 3 percent to 5 percent and no hold-harmless provisions are drawn from the ADAP supplemental pool. A State is eligible if the State did not have unobligated funds subject to reallocation in the previous fiscal year and demonstrates severe need for the grant. The Secretary shall consider certain specified criteria when determining need. A State cannot receive a demonstrated need supplemental award unless it makes available non-federal contributions in an amount equal to $1 for each $4 of Federal funds provided for the grant. The Secretary shall waive the match for the severe need supplemental award, as long as the State provided its Part B base formula match.

This section provides for a hold-harmless for States for fiscal years 2007 through 2009 at 95 percent of the formula amount of the previous fiscal year. The Part B overall hold-harmless is triggered when the sum of the amounts received in the ADAP base award and Part B base formula award equals less than 95 percent of the previous year's award. In allocating funds for the hold-harmless provisions, the funding will first be deducted from the Part B (not ADAP) supplemental pool. Once the funds from the Part B (not ADAP) supplemental pool are exhausted, then there will be a pro rata reduction, removing from those reductions those States needing the hold-harmless provisions and States receiving the small state minimum.

Section 204. Additional amendments to subpart I of Part B

Section 204 provides additional amendments to subpart I of Part B. It requires States to designate a lead State agency that administers all assistance received; conducts a needs assessment and prepares a State plan; prepares all applications; receives notices regarding programs; collects and submits to the Secretary every two years all audits from grantees within the State, including an audit regarding funds expended; carries out any other duties determined by the Secretary to facilitate the coordination of the program. Each grant application submitted must include key outcomes to be measured by all entities in the State receiving assistance under Part B.

This section also requires representation by Federally recognized Indian tribes in the planning process and exempts the Indian Health Service from the payer of last resort provision.

Section 205. Supplemental grants on basis of demonstrated need

Section 205 creates a new Part B base supplemental grant pool with enumerated criteria for determining whether a State has a demonstrated need for supplemental awards as under Section 103. It also provides for the prioritization of a supplemental grant award for States that meet the criteria set forth in the section, similar to that provided under Section 103.

Section 206. Emerging communities

Section 206 clarifies that grants received will be used to provide funds directly to Emerging Communities and are separate from Part B funds. Eligibility to be an Emerging Community is 500–999 cumulative AIDS cases reported in the last five years. Eligibility

would be maintained until a grantee went below the eligibility threshold and below an overall prevalence test (750 living AIDS cases) for three consecutive years, at which time it would become ineligible.

Section 207. Timeframe for obligation and expenditure of grant funds

Section 207 has the same provisions in Section 104 regarding the timeframe for obligation and expenditure of funds, except that unobligated funds are reallocated to the Part B supplemental grant pool.

Section 208. Authorization of appropriations for subpart I of Part B

Section 208 provides an increase of $70 million in authorized funds for fiscal year 2007 and a 3.7 percent increase in authorization levels for each of fiscal years 2008 through 2011. Five million dollars of the authorized appropriations are set aside each year of the reauthorization for Emerging Communities. The new Part B base supplemental grant pool is funded by setting aside one-third of any additional funds appropriated for Part B base (not ADAP) over the fiscal year 2006 level.

Section 209. Early Diagnosis Grant Program

Section 209 authorizes $30 million for fiscal years 2007 through 2011 for the new Early Diagnosis Grant Program awards. Twenty million dollars of this amount shall be distributed to those States that offer voluntary opt-out testing of pregnant women and universal testing of newborns. Ten million dollars of this amount shall be distributed to those States that offer voluntary opt-out testing of clients at sexually transmitted disease clinics and voluntary opt-out testing of clients at substance abuse treatment centers.

Section 210. Certain partner notification programs; authorization of appropriations

Section 210 authorizes $10 million for each of fiscal years 2007 through 2011 for certain partner notification programs.

TITLE III—EARLY INTERVENTION SERVICES

Section 301. Establishment of program; core medical services

Section 301 provides for grants to certain public and nonprofit entities and applies the same 75/25 requirement for core medical services and the same administrative expense cap (including the provision regarding funds used for the clinical quality management program) contained in sections 105 and 201.

Section 302. Eligible Entities; Preferences; Planning and Development Grants

Section 302 provides a defined list of eligible entities for purposes of awarding Part C grants. It specifies that Part C grantees serve underserved populations and provides examples of these populations. It adds to the preference in making grants the number of cases of individuals co-infected with HIV/AIDS and hepatitis B or C as a consideration.

Section 303. Authorization of appropriations

Section 303 provides an increase of $25 million in authorized fund for fiscal year 2007 and authorizes a 3.7 percent increase in authorization levels for each of fiscal years 2008 through 2011.

Section 304. Confidentiality and informed consent

Section 304 includes provisions regarding the confidentiality of information regarding the receipt of early intervention services, and use of informed consent.

Section 305. Provision of certain counseling services

Section 305 includes provisions regarding the counseling of individuals with negative HIV/AIDS test results, as well as the counseling of individuals with positive HIV/AIDS test results. It also includes a provision regarding the counseling of emergency response employees.

Section 306. General provisions

Section 306 requires Part C grantees to submit information on how grant expenditures are related to the planning process for eligible areas funded under Part A and States funded under Part B, as well as how grant expenditures will improve overall client outcomes. The grant applicant must agree to provide additional documentation on how the community provided input into the proposed grant activities. The applicant must also agree to submit, to the lead State agency, audits every two years regarding fund expenditures and the necessary client-level data to complete unmet need calculations and Statewide coordinated statements of need process.

This section also exempts the Indian Health Service from the payer of last resort provision.

TITLE IV—WOMEN, INFANTS, CHILDREN, AND YOUTH

Section 401. Women, infants, children, and youth

Section 401 clarifies that a health facility operated by or pursuant to a contract with the Indian Health Service is eligible as a direct grantee. It also clarifies that the current focus of the Title IV activities is on family-centered care (not research), while still maintaining a strong link with the research community. It specifies that the applicant must coordinate with other providers of health care services and dictates that every grantee must submit an audit regarding funds expended to their State every two years. Administrative expenses are capped at 10 percent (funds used for clinical quality management programs are not included in this cap). No more than five percent of funds may be used to provide training and technical assistance to grantees. Grantees must complete an annual review and evaluation of Part D programs. This section authorizes $71.8 million for each of fiscal years 2007–2011.

Section 402. GAO report

Section 402 requires the Government Accountability Office (GAO) to conduct an evaluation, and submit to Congress a report, concerning the funding provided under Part D.

TITLE V—GENERAL PROVISIONS

Section 501. General provisions

Section 501 requires coordination among Federal agencies for planning, funding, and implementing Federal HIV programs. It requires States and local government and private nonprofits to ensure Ryan White services are integrated with other programs. It requires every grantee to submit an audit to its State (or, in the case of a State, to the Secretary) every other year. Audits will be posted on the Internet.

This section also provides the Secretary with flexibility to ensure individuals receiving services through this program have access to care in the case of a public health emergency or equivalent thereof. It requires the Secretary to ensure that any information submitted to, or collected by, the Secretary excludes any personally identifiable information.

The section requires GAO to submit biennially to the appropriate committees of Congress a report that includes a description of Federal, State, and local barriers to HIV program integration, particularly for racial and ethnic minorities, and recommendations for enhancing the continuity of care.

TITLE VI—DEMONSTRATION AND TRAINING

Section 601. Demonstrations and training

Section 601 requires the SPNS program to focus on: (1) development of health information technology systems to support client-level data, as it relates to the severity of need index; and (2) responding to emerging needs of populations served by Ryan White. Twenty million dollars is allocated for development of health information technology systems and $5 million is allocated for emerging needs.

Section 602. AIDS education and training centers

Section 602 provides a preference to projects that train health professionals to provide treatment to Native American HIV/AIDS patients. It also clarifies that training of health professionals may be related to hepatitis B and C.

This section authorizes $34,700,000 for each of fiscal years 2007 through 2011 for schools and centers and $13,000,000 for each of fiscal years for 2007 through 2011 for dental schools.

Section 603. Codification of Minority AIDS Initiative

Section 603 codifies the Minority AIDS Initiative and provides a 3.7% annual increase in authorization levels for each of fiscal years 2008 through 2011.

TITLE VII—MISCELLANEOUS PROVISIONS

Section 701. Hepatitis; use of funds

Section 701 specifies that information shall be provided on the transmission and prevention of hepatitis A, B, and C, including education about the availability of hepatitis A and B vaccines and assisting patients in identifying vaccination sites.

Section 702. Certain definitions

Section 702 includes definitions of certain references throughout the bill.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * * * *

TITLE XXVI—HIV HEALTH CARE SERVICES PROGRAM

* * * * * * *

PART A—Emergency Relief for Areas With Substantial Need for Services

Subpart I—General Grant Provisions

SEC. 2601. ESTABLISHMENT OF PROGRAM OF GRANTS.

(a) ELIGIBLE AREAS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall, subject to subsections (b) [through (d)] *through (c)*, make grants in accordance with section 2603 for the purpose of assisting in the provision of the services specified in section 2604 in any metropolitan area for which there has been reported to *and confirmed by* the Director of the Centers for Disease Control and Prevention a cumulative total of more than 2,000 cases of [acquired immune deficiency syndrome for the most recent period] *AIDS during the most recent period* of 5 calendar years for which such data are available.

[(b) REQUIREMENT REGARDING CONFIRMATION OF CASES.—The Secretary may not make a grant under subsection (a) for a metropolitan area unless, before making any payments under the grant, the cases of acquired immune deficiency syndrome reported for purposes of such subsection have been confirmed by the Secretary, acting through the Director of the Centers for Disease Control and Prevention.

[(c) REQUIREMENTS REGARDING POPULATION.—

[(1) NUMBER OF INDIVIDUALS.—

[(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary may not make a grant under this section for a metropolitan area unless the area has a population of 500,000 or more individuals.

[(B) LIMITATION.—Subparagraph (A) does not apply to any metropolitan area that was an eligible area under this part for fiscal year 1995 or any prior fiscal year.

[(2) GEOGRAPHIC BOUNDARIES.—For purposes of eligibility under this part, the boundaries of each metropolitan area are the boundaries that were in effect for the area for fiscal year 1994.

[(d) CONTINUED STATUS AS ELIGIBLE AREA.—Notwithstanding any other provision of this section, a metropolitan area that was an eligible area under this part for fiscal year 1996 is an eligible area for fiscal year 1997 and each subsequent fiscal year.]

(b) CONTINUED STATUS AS ELIGIBLE AREA.—Notwithstanding any other provision of this section, a metropolitan area that is an eligible area for a fiscal year continues to be an eligible area until the metropolitan area fails, for three consecutive fiscal years—

(1) to meet the requirements of subsection (a); and

(2) to have a cumulative total of 3,000 or more living cases of AIDS (reported to and confirmed by the Director of the Centers for Disease Control and Prevention) as of December 31 of the most recent calendar year for which such data is available.

(c) BOUNDARIES.—For purposes of determining eligibility under this part—

(1) with respect to a metropolitan area that received funding under this part in fiscal year 2006, the boundaries of such metropolitan area shall be the boundaries that were in effect for such area for fiscal year 1994; or

(2) with respect to a metropolitan area that becomes eligible to receive funding under this part in any fiscal year after fiscal year 2006, the boundaries of such metropolitan area shall be the boundaries that are in effect for such area when such area initially receives funding under this part.

SEC. 2602. ADMINISTRATION AND PLANNING COUNCIL.

(a) ADMINISTRATION.—

(1) IN GENERAL.—Assistance made available under grants awarded under [this part] *this subpart* shall be directed to the chief elected official of the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of individuals with AIDS, as reported to and confirmed by the Centers for Disease Control and Prevention, in the eligible area that is awarded such a grant.

* * * * * * *

(b) HIV HEALTH SERVICES PLANNING COUNCIL.—

(1) ESTABLISHMENT.—To be eligible for assistance under [this part] *this subpart*, the chief elected official described in subsection (a)(1) shall establish or designate an HIV health services planning council that shall reflect in its composition the demographics of the population of individuals with [HIV disease] *HIV/AIDS* in the eligible area involved, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations. Nominations for membership on the council shall be identified through an open process and candidates shall be selected based on locally delineated and publicized criteria. Such criteria shall include a conflict-of-interest standard that is in accordance with paragraph (5).

(2) REPRESENTATION.—The HIV health services planning council shall include representatives of—

(A) * * *

* * * * * * *

(G) affected communities, including people with [HIV disease] *HIV/AIDS, members of a Federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C* and historically underserved groups and subpopulations;

* * * * * * *

(M) representatives of individuals who formerly were Federal, State, or local prisoners, were released from the custody of the penal system during the preceding 3 years, and had [HIV disease] *HIV/AIDS* as of the date on which the individuals were so released.

* * * * * * *

(4) DUTIES.—The planning council established or designated under paragraph (1) shall—

(A) determine the size and demographics of the population of individuals with [HIV disease] *HIV/AIDS*;

(B) determine the needs of such population, with particular attention to—

(i) individuals with [HIV disease] *HIV/AIDS* who know their HIV status and are not receiving HIV-related services; and

* * * * * * *

(C) establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a grantee should consider in allocating funds under a grant based on the—

(i) size and demographics of the population of individuals with [HIV disease] *HIV/AIDS* (as determined under subparagraph (A)) and the needs of such population (as determined under subparagraph (B));

* * * * * * *

(iii) priorities of the communities with [HIV disease] *HIV/AIDS* for whom the services are intended;

* * * * * * *

(v) availability of other governmental and non-governmental resources, including the State medicaid plan under title XIX of the Social Security Act and the State Children's Health Insurance Program under title XXI of such Act to cover health care costs of eligible individuals and families with [HIV disease] *HIV/AIDS*; and

* * * * * * *

(D) develop a comprehensive plan for the organization and delivery of health and support services described in section 2604 that—

(i) * * *

* * * * * * *

(iii) is compatible with any State or local plan for the provision of services to individuals with [HIV disease] *HIV/AIDS*;

* * * * * * *

(5) CONFLICTS OF INTEREST.—

(A) * * *

* * * * * * *

(C) COMPOSITION OF COUNCIL.—The following applies regarding the membership of a planning council under paragraph (1):

(i) Not less than 33 percent of the council shall be individuals who are receiving HIV-related services pursuant to a grant under section 2601(a), are not officers, employees, or consultants to any entity that receives amounts from such a grant, and do not represent any such entity, and reflect the demographics of the population of individuals with [HIV disease] *HIV/AIDS* as determined under paragraph (4)(A). For purposes of the preceding sentence, an individual shall be considered to be receiving such services if the individual is a parent of, or a caregiver for, a minor child who is receiving such services.

* * * * * * *

(6) GRIEVANCE PROCEDURES.—A planning council under paragraph (1) shall develop procedures for addressing grievances with respect to funding under [this part] *this subpart*, including procedures for submitting grievances that cannot be resolved to binding arbitration. Such procedures shall be described in the by-laws of the planning council and be consistent with the requirements of subsection (c).

* * * * * * *

(c) GRIEVANCE PROCEDURES.—

(1) FEDERAL RESPONSIBILITY.—

(A) MODELS.—The Secretary shall, through a process that includes consultations with grantees under [this part] *this subpart* and public and private experts in grievance procedures, arbitration, and mediation, develop model grievance procedures that may be implemented by the planning council under subsection (b)(1) and grantees under [this part] *this subpart*. Such model procedures shall describe the elements that must be addressed in establishing local grievance procedures and provide grantees with flexibility in the design of such local procedures.

(B) REVIEW.—The Secretary shall review grievance procedures established by the planning council and grantees under [this part] *this subpart* to determine if such procedures are adequate. In making such a determination, the Secretary shall assess whether such procedures permit legitimate grievances to be filed, evaluated, and resolved at the local level.

(2) GRANTEES.—To be eligible to receive funds under [this part] *this subpart*, a grantee shall develop grievance procedures that are determined by the Secretary to be consistent with the model procedures developed under paragraph (1)(A). Such procedures shall include a process for submitting grievances to binding arbitration.

(d) PROCESS FOR ESTABLISHING ALLOCATION PRIORITIES.—Promptly after the date of the submission of the report required in section 501(b) of the Ryan White CARE Act Amendments of 2000 (relating to the relationship between epidemiological measures and health care for certain individuals with [HIV disease] *HIV/AIDS*), the Secretary, in consultation with planning councils and entities that receive amounts from grants under section 2601(a) or 2611, shall develop epidemiologic measures—

(1) for establishing the number of individuals living with [HIV disease] *HIV/AIDS* who are not receiving HIV-related health services; and

* * * * * * *

SEC. 2603. TYPE AND DISTRIBUTION OF GRANTS.

(a) GRANTS BASED ON RELATIVE NEED OF AREA.—

(1) * * *

(2) EXPEDITED DISTRIBUTION.—Not later than 60 days after an appropriation becomes available to carry out [this part] *this subpart* for a fiscal year, the Secretary shall, except in the case of waivers granted under section 2605(c), disburse [50 percent of the amount appropriated under section 2677] *66⅔ percent of the amount made available under section 2610(b) for carrying out this subpart* for such fiscal year through grants to eligible areas under section 2601(a), in accordance with [paragraph (3)] *paragraphs (3) and (4)*. [The Secretary shall reserve an additional percentage of the amount appropriated under section 2677 for a fiscal year for grants under part A to make grants to eligible areas under section 2601(a) in accordance with paragraph (4).]

(3) AMOUNT OF GRANT.—

(A) IN GENERAL.—Subject to the extent of amounts made available in appropriations Acts, a grant made for purposes of this paragraph to an eligible area shall be made in an amount equal to the product of—

(i) * * *

(ii) the percentage constituted by the ratio of the distribution factor for the eligible area to the sum of the respective distribution factors for all eligible areas.which product shall then, as applicable, be increased under paragraph (4)[.]*;*

which product shall then, as applicable, be increased under paragraph (4).

(B) DISTRIBUTION FACTOR.—For purposes of subparagraph (A)(ii), the term "distribution factor" means an amount equal to the [estimated number of living cases of acquired immune deficiency syndrome] *living cases of HIV/AIDS (reported to and confirmed by the Director of the Centers for Disease Control and Prevention)* in the eligible area involved, as determined under subparagraph (C).

[(C) ESTIMATE OF LIVING CASES.—The amount determined in this subparagraph is an amount equal to the product of—

[(i) the number of cases of acquired immune deficiency syndrome in the eligible area during each year

in the most recent 120-month period for which data are available with respect to all eligible areas, as indicated by the number of such cases reported to and confirmed by the Director of the Centers for Disease Control and Prevention for each year during such period, except that (subject to subparagraph (D)), for grants made pursuant to this paragraph for fiscal year 2005 and subsequent fiscal years, the cases counted for each 12-month period beginning on or after July 1, 2004, shall be cases of HIV disease (as reported to and confirmed by such Director) rather than cases of acquired immune deficiency syndrome; and

[(ii) with respect to—

[(I) the first year during such period, .06;

[(II) the second year during such period, .06;

[(III) the third year during such period, .08;

[(IV) the fourth year during such period, .10;

[(V) the fifth year during such period, .16;

[(VI) the sixth year during such period, .16;

[(VII) the seventh year during such period, .24;

[(VIII) the eighth year during such period, .40;

[(IX) the ninth year during such period, .57; and

[(X) the tenth year during such period, .88.

The yearly percentage described in subparagraph (ii) shall be updated biennially by the Secretary, after consultation with the Centers for Disease Control and Prevention, and shall be reported to the congressional committees of jurisdiction. The first such update shall occur prior to the determination of grant awards under this part for fiscal year 1998. Updates shall as applicable take into account the counting of cases of HIV disease pursuant to clause (i).

[(D) DETERMINATION OF SECRETARY REGARDING DATA ON HIV CASES.—

[(i) IN GENERAL.—Not later than July 1, 2004, the Secretary shall determine whether there is data on cases of HIV disease from all eligible areas (reported to and confirmed by the Director of the Centers for Disease Control and Prevention) sufficiently accurate and reliable for use for purposes of subparagraph (C)(i). In making such a determination, the Secretary shall take into consideration the findings of the study under section 501(b) of the Ryan White CARE Act Amendments of 2000 (relating to the relationship between epidemiological measures and health care for certain individuals with HIV disease).

[(ii) EFFECT OF ADVERSE DETERMINATION.—If under clause (i) the Secretary determines that data on cases of HIV disease is not sufficiently accurate and reliable for use for purposes of subparagraph (C)(i), then notwithstanding such subparagraph, for any fiscal year prior to fiscal year 2007 the references in such subparagraph to cases of HIV disease do not have any legal effect.

[(iii) GRANTS AND TECHNICAL ASSISTANCE REGARDING COUNTING OF HIV CASES.—Of the amounts appropriated under section 318B for a fiscal year, the Secretary shall reserve amounts to make grants and provide technical assistance to States and eligible areas with respect to obtaining data on cases of HIV disease to ensure that data on such cases is available from all States and eligible areas as soon as is practicable but not later than the beginning of fiscal year 2007.

[(E) UNEXPENDED FUNDS.—The Secretary may, in determining the amount of a grant for a fiscal year under this paragraph, adjust the grant amount to reflect the amount of unexpended and uncanceled grant funds remaining at the end of the fiscal year preceding the year for which the grant determination is to be made. The amount of any such unexpended funds shall be determined using the financial status report of the grantee.]

(C) LIVING CASES OF HIV/AIDS.—

(i) REQUIREMENT OF NAMES-BASED REPORTING.—Except as provided in clause (ii), the number determined under this subparagraph for an eligible area for a fiscal year for purposes of subparagraph (B) is the number of living names-based cases of HIV/AIDS that, as of December 31 of the most recent calendar year for which such data is available, have been reported to and confirmed by the Director of the Centers for Disease Control and Prevention.

(ii) TRANSITION PERIOD; EXEMPTION REGARDING NON-AIDS CASES.—For each of the fiscal years 2007 through 2010, an eligible area is, subject to clauses (iii) through (v), exempt from the requirement under clause (i) that living names-based non-AIDS cases of HIV be reported unless—

(I) a system was in operation as of December 31, 2005, that provides sufficiently accurate and reliable names-based reporting of such cases throughout the State in which the area is located, subject to clause (viii); or

(II) no later than the beginning of fiscal year 2008, 2009, or 2010, the Secretary, in consultation with the chief executive of the State in which the area is located, determines that a system has become operational in the State that provides sufficiently accurate and reliable names-based reporting of such cases throughout the State.

(iii) REQUIREMENTS FOR EXEMPTION FOR FISCAL YEAR 2007.—For fiscal year 2007, an exemption under clause (ii) for an eligible area applies only if, by October 1, 2006—

(I)(aa) the State in which the area is located had submitted to the Secretary a plan for making the transition to sufficiently accurate and reliable names-based reporting of living non-AIDS cases of HIV; or

(bb) all statutory changes necessary to provide for sufficiently accurate and reliable reporting of such cases had been made; and

(II) the State had agreed that, by April 1, 2008, the State will begin accurate and reliable names-based reporting of such cases, except that such agreement is not required to provide that, as of such date, the system for such reporting be fully sufficient with respect to accuracy and reliability throughout the area.

(iv) REQUIREMENT FOR EXEMPTION AS OF FISCAL YEAR 2008.—For each of the fiscal years 2008 through 2010, an exemption under clause (ii) for an eligible area applies only if, as of April 1, 2008, the State in which the area is located is substantially in compliance with the agreement under clause (iii)(II).

(v) PROGRESS TOWARD NAMES-BASED REPORTING.—For fiscal year 2009 or 2010, the Secretary may terminate an exemption under clause (ii) for an eligible area if the State in which the area is located submitted a plan under clause (iii)(I)(aa) and the Secretary determines that the State is not substantially following the plan.

(vi) COUNTING OF CASES IN AREAS WITH EXEMPTIONS.—

(I) IN GENERAL.—With respect to an eligible area that is under a reporting system for living non-AIDS cases of HIV that is not names-based (referred to in this subparagraph as "code-based reporting"), the Secretary shall, for purposes of this subparagraph, modify the number of such cases reported for the eligible area in order to adjust for duplicative reporting in and among systems that use code-based reporting.

(II) ADJUSTMENT RATE.—The adjustment rate under subclause (I) for an eligible area shall be a reduction of 5 percent in the number of living non-AIDS cases of HIV reported for the area.

(vii) MULTIPLE POLITICAL JURISDICTIONS.—With respect to living non-AIDS cases of HIV, if an eligible area is not entirely within one political jurisdiction and as a result is subject to more than one reporting system for purposes of this subparagraph:

(I) Names-based reporting under clause (i) applies in a jurisdictional portion of the area, or an exemption under clause (ii) applies in such portion (subject to applicable provisions of this subparagraph), according to whether names-based reporting or code-based reporting is used in such portion.

(II) If under subclause (I) both names-based reporting and code-based reporting apply in the area, the number of code-based cases shall be reduced under clause (vi).

(viii) LIST OF ELIGIBLE AREAS MEETING STANDARD REGARDING DECEMBER 31, 2005.—

(I) IN GENERAL.—If an eligible area or portion thereof is in a State specified in subclause (II), the eligible area or portion shall be considered to meet the standard described in clause (ii)(I). No other eligible area or portion thereof may be considered to meet such standard.

(II) RELEVANT STATES.—For purposes of subclause (I), the States specified in this subclause are the following: Alaska, Alabama, Arkansas, Arizona, Colorado, Florida, Indiana, Iowa, Idaho, Kansas, Louisiana, Michigan, Minnesota, Missouri, Mississippi, North Carolina, North Dakota, Nebraska, New Jersey, New Mexico, New York, Nevada, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, West Virginia, Wyoming, Guam, and the Virgin Islands.

(ix) RULES OF CONSTRUCTION REGARDING ACCEPTANCE OF REPORTS.—

(I) CASES OF AIDS.—With respect to an eligible area that is subject to the requirement under clause (i) and is not in compliance with the requirement for names-based reporting of living non-AIDS cases of HIV, the Secretary shall, notwithstanding such noncompliance, accept reports of living cases of AIDS that are in accordance with such clause.

(II) APPLICABILITY OF EXEMPTION REQUIREMENTS.—The provisions of clauses (ii) through (viii) may not be construed as having any legal effect for fiscal year 2011 or any subsequent fiscal year, and accordingly, the status of a State for purposes of such clauses may not be considered after fiscal year 2010.

(x) PROGRAM FOR DETECTING INACCURATE OR FRAUDULENT COUNTING.—The Secretary shall carry out a program to monitor the reporting of names-based cases for purposes of this subparagraph and to detect instances of inaccurate reporting, including fraudulent reporting.

(D) CODE-BASED AREAS; LIMITATION ON INCREASE IN GRANT .—

(i) IN GENERAL.—For each of the fiscal years 2007 through 2010, if code-based reporting (within the meaning of subparagraph (C)(vi)) applies in an eligible area or any portion thereof as of the beginning of the fiscal year involved, then notwithstanding any other provision of this paragraph, the amount of the grant pursuant to this paragraph for such area for such fiscal year may not—

(I) for fiscal year 2007, exceed by more than 5 percent the amount of the grant for the area that would have been made pursuant to this paragraph and paragraph (4) for fiscal year 2006 (as such paragraphs were in effect for such fiscal year) if

paragraph (2) (as so in effect) had been applied by substituting "66⅔ percent" for "50 percent"; and

(II) for each of the fiscal years 2008 and 2009, exceed by more than 5 percent the amount of the grant pursuant to this paragraph and paragraph (4) for the area for the preceding fiscal year.

(ii) USE OF AMOUNTS INVOLVED.—For each of the fiscal years 2007 through 2010, amounts available as a result of the limitation under clause (i) shall be made available by the Secretary as additional amounts for grants pursuant to subsection (b) for the fiscal year involved, subject to paragraph (4) and section 2610(d)(2).

[(4) INCREASES IN GRANT.—

[(A) IN GENERAL.—For each fiscal year in a protection period for an eligible area, the Secretary shall increase the amount of the grant made pursuant to paragraph (2) for the area to ensure that—

[(i) for the first fiscal year in the protection period, the grant is not less than 98 percent of the amount of the grant made for the eligible area pursuant to such paragraph for the base year for the protection period;

[(ii) for any second fiscal year in such period, the grant is not less than 95 percent of the amount of such base year grant;

[(iii) for any third fiscal year in such period, the grant is not less than 92 percent of the amount of the base year grant;

[(iv) for any fourth fiscal year in such period, the grant is not less than 89 percent of the amount of the base year grant; and

[(v) for any fifth or subsequent fiscal year in such period, if, pursuant to paragraph (3)(D)(ii), the references in paragraph (3)(C)(i) to HIV disease do not have any legal effect, the grant is not less than 85 percent of the amount of the base year grant.

[(B) SPECIAL RULE.—If for fiscal year 2005, pursuant to paragraph (3)(D)(ii), data on cases of HIV disease are used for purposes of paragraph (3)(C)(i), the Secretary shall increase the amount of a grant made pursuant to paragraph (2) for an eligible area to ensure that the grant is not less than 98 percent of the amount of the grant made for the area in fiscal year 2004.

[(C) BASE YEAR; PROTECTION PERIOD.—With respect to grants made pursuant to paragraph (2) for an eligible area:

[(i) The base year for a protection period is the fiscal year preceding the trigger grant-reduction year.

[(ii) The first trigger grant-reduction year is the first fiscal year (after fiscal year 2000) for which the grant for the area is less than the grant for the area for the preceding fiscal year.

[(iii) A protection period begins with the trigger grant-reduction year and continues until the beginning of the first fiscal year for which the amount of the grant determined pursuant to paragraph (2) for the

area equals or exceeds the amount of the grant determined under subparagraph (A).

[(iv) Any subsequent trigger grant-reduction year is the first fiscal year, after the end of the preceding protection period, for which the amount of the grant is less than the amount of the grant for the preceding fiscal year.]

(4) INCREASES IN GRANT.—

(A) IN GENERAL.—For each eligible area that received a grant pursuant to this subsection for fiscal year 2006, the Secretary shall, for each of the fiscal years 2007 through 2009, increase the amount of the grant made pursuant to paragraph (3) for the area to ensure that the amount of the grant for the fiscal year involved is not less than the following amount, as applicable to such fiscal year:

(i) For fiscal year 2007, an amount equal to 95 percent of the amount of the grant that would have been made pursuant to paragraph (3) and this paragraph for fiscal year 2006 (as such paragraphs were in effect for such fiscal year) if paragraph (2) (as so in effect) had been applied by substituting "66⅔ percent" for "50 percent".

(ii) For each of the fiscal years 2008 and 2009, an amount equal to 95 percent of the amount of the grant made pursuant to paragraph (3) and this paragraph for the preceding fiscal year.

(B) SOURCE OF FUNDS FOR INCREASE.—

(i) IN GENERAL.—From the amounts available for carrying out the single program referred to in section 2609(d)(2)(C) for a fiscal year (relating to supplemental grants), the Secretary shall make available such amounts as may be necessary to comply with subparagraph (A), subject to section 2610(d)(2).

(ii) PRO RATA REDUCTION.—If the amounts referred to in clause (i) for a fiscal year are insufficient to fully comply with subparagraph (A) for the year, the Secretary, in order to provide the additional funds necessary for such compliance, shall reduce on a pro rata basis the amount of each grant pursuant to this subsection for the fiscal year, other than grants for eligible areas for which increases under subparagraph (A) apply. A reduction under the preceding sentence may not be made in an amount that would result in the eligible area involved becoming eligible for such an increase.

(C) LIMITATION.—This paragraph may not be construed as having any applicability after fiscal year 2009.

(b) SUPPLEMENTAL GRANTS.—

(1) IN GENERAL.—[Not later than 150 days after the date on which appropriations are made under section 2677 for a fiscal year, the Secretary shall] *Subject to subsection (a)(4)(B)(i) and section 2610(d), the Secretary shall* disburse the remainder of amounts not disbursed under section 2603(a)(2) for such fiscal year for the purpose of making grants under section 2601(a) to eligible areas whose application under section 2605(b)—

(A) * * *

(B) [demonstrates the severe need in such area] *demonstrates the need in such area, on an objective and quantified basis,* for supplemental financial assistance to combat the HIV epidemic;

* * * * * * *

(E) demonstrates that resources will be allocated in accordance with the local demographic incidence of AIDS including appropriate allocations for services for infants, children, youth, women, and families with [HIV disease] *HIV/AIDS*;

[(F) demonstrates the inclusiveness of the planning council membership, with particular emphasis on affected communities and individuals with HIV disease; and]

(F) demonstrates the inclusiveness of affected communities and individuals with HIV/AIDS;

(G) demonstrates the manner in which the proposed services are consistent with the local needs assessment and the statewide coordinated statement of need[.]*; and*

(H) demonstrates the ability of the applicant to expend funds efficiently by not having had, for the most recent grant year under subsection (a) for which data is available, more than 2 percent of grant funds under such subsection canceled or covered by any waivers under subsection (c)(3).

(2) AMOUNT OF GRANT.—

(A) IN GENERAL.—The amount of each grant made for purposes of this subsection shall be determined by the Secretary based on a weighting of factors under paragraph (1), with [severe need] *demonstrated need* under subparagraph (B) of such paragraph counting one-third.

[(B) SEVERE NEED.—In determining severe need in accordance with paragraph (1)(B), the Secretary shall consider the ability of the qualified applicant to expend funds efficiently and the impact of relevant factors on the cost and complexity of delivering health care and support services to individuals with HIV disease in the eligible area, including factors such as—

[(i) sexually transmitted diseases, substance abuse, tuberculosis, severe mental illness, or other comorbid factors determined relevant by the Secretary;

[(ii) new or growing subpopulations of individuals with HIV disease;

[(iii) homelessness;

[(iv) the current prevalence of HIV disease;

[(v) an increasing need for HIV-related services, including relative rates of increase in the number of cases of HIV disease; and

[(vi) unmet need for such services, as determined under section 2602(b)(4).]

(B) DEMONSTRATED NEED.—The factors considered by the Secretary in determining whether an eligible area has a demonstrated need for purposes of paragraph (1)(B) may include any or all of the following:

(i) The unmet need for such services, as determined under section 2602(b)(4) or other community input process as defined under section 2609(d)(1)(A).

(ii) An increasing need for HIV/AIDS-related services, including relative rates of increase in the number of cases of HIV/AIDS.

(iii) The relative rates of increase in the number of cases of HIV/AIDS within new or emerging subpopulations.

(iv) The current prevalence of HIV/AIDS.

(v) Relevant factors related to the cost and complexity of delivering health care to individuals with HIV/AIDS in the eligible area.

(vi) The impact of co-morbid factors, including co-occurring conditions, determined relevant by the Secretary.

(vii) The prevalence of homelessness.

(viii) The prevalence of individuals described under section 2602(b)(2)(M).

(ix) The relevant factors that limit access to health care, including geographic variation, adequacy of health insurance coverage, and language barriers.

(x) The impact of a decline in the amount received pursuant to subsection (a) on services available to all individuals with HIV/AIDS identified and eligible under this title.

[(C) PREVALENCE.—In determining the impact of the factors described in subparagraph (B), the Secretary shall, to the extent practicable, use national, quantitative incidence data that are available for each eligible area. Not later than 18 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000, the Secretary shall develop a mechanism to utilize such data. Such a mechanism shall be modified to reflect the findings of the study under section 501(b) of the Ryan White CARE Act Amendments of 2000 (relating to the relationship between epidemiological measures and health care for certain individuals with HIV disease). In the absence of such data, the Secretary may consider a detailed description and qualitative analysis of severe need, as determined under subparagraph (B), including any local prevalence data gathered and analyzed by the eligible area.

[(D) PRIORITY.—Subsequent to the development of the quantitative mechanism described in subparagraph (C), the Secretary shall phase in, over a 3-year period beginning in fiscal year 1998, the use of such a mechanism to determine the severe need of an eligible area compared to other eligible areas and to determine, in part, the amount of supplemental funds awarded to the eligible area under this part.]

(C) PRIORITY IN MAKING GRANTS.—The Secretary shall provide funds under this subsection to an eligible area to address the decline in services related to the decline in the amounts received pursuant to subsection (a) consistent with the grant award for the eligible area for fiscal year 2006,

to the extent that the factor under subparagraph (B)(x) (relating to a decline in funding) applies to the eligible area.

* * * * * * *

(c) TIMEFRAME FOR OBLIGATION AND EXPENDITURE OF GRANT FUNDS.—

(1) OBLIGATION BY END OF GRANT YEAR.—Effective for fiscal year 2007 and subsequent fiscal years, funds from a grant award made pursuant to subsection (a) or (b) for a fiscal year are available for obligation by the eligible area involved through the end of the one-year period beginning on the date in such fiscal year on which funds from the award first become available to the area (referred to in this subsection as the "grant year for the award"), except as provided in paragraph (3)(A).

(2) SUPPLEMENTAL GRANTS; CANCELLATION OF UNOBLIGATED BALANCE OF GRANT AWARD.—Effective for fiscal year 2007 and subsequent fiscal years, if a grant award made pursuant to subsection (b) for an eligible area for a fiscal year has an unobligated balance as of the end of the grant year for the award—

(A) the Secretary shall cancel that unobligated balance of the award, and shall require the eligible area to return any amounts from such balance that have been disbursed to the area; and

(B) the funds involved shall be made available by the Secretary as additional amounts for grants pursuant to subsection (b) for the first fiscal year beginning after the fiscal year in which the Secretary obtains the information necessary for determining that the balance is required under subparagraph (A) to be canceled, except that the availability of the funds for such grants is subject to subsection (a)(4) and section 2610(d)(2) as applied for such year.

(3) FORMULA GRANTS; CANCELLATION OF UNOBLIGATED BALANCE OF GRANT AWARD; WAIVER PERMITTING CARRYOVER.—

(A) IN GENERAL.—Effective for fiscal year 2007 and subsequent fiscal years, if a grant award made pursuant to subsection (a) for an eligible area for a fiscal year has an unobligated balance as of the end of the grant year for the award, the Secretary shall cancel that unobligated balance of the award, and shall require the eligible area to return any amounts from such balance that have been disbursed to the area, unless—

(i) before the end of the grant year, the chief executive officer of the area submits to the Secretary a written application for a waiver of the cancellation, which application includes a description of the purposes for which the area intends to expend the funds involved; and

(ii) the Secretary approves the waiver.

(B) EXPENDITURE BY END OF CARRYOVER YEAR.—With respect to a waiver under subparagraph (A) that is approved for a balance that is unobligated as of the end of a grant year for an award:

(i) The unobligated funds are available for expenditure by the eligible area involved for the one-year pe-

riod beginning upon the expiration of the grant year (referred to in this subsection as the "carryover year").

(ii) If the funds are not expended by the end of the carryover year, the Secretary shall cancel that unexpended balance of the award, and shall require the eligible area to return any amounts from such balance that have been disbursed to the area.

(C) USE OF CANCELLED BALANCES.—In the case of any balance of a grant award that is cancelled under subparagraph (A) or (B)(ii), the grant funds involved shall be made available by the Secretary as additional amounts for grants pursuant to subsection (b) for the first fiscal year beginning after the fiscal year in which the Secretary obtains the information necessary for determining that the balance is required under such subparagraph to be canceled, except that the availability of the funds for such grants is subject to subsection (a)(4) and section 2610(d)(2) as applied for such year.

(D) CORRESPONDING REDUCTION IN FUTURE GRANT.—

(i) IN GENERAL.—In the case of an eligible area for which a balance from a grant award under subsection (a) is unobligated as of the end of the grant year for the award—

(I) the Secretary shall reduce, by the same amount as such unobligated balance, the amount of the grant under such subsection for the first fiscal year beginning after the fiscal year in which the Secretary obtains the information necessary for determining that such balance was unobligated as of the end of the grant year (which requirement for a reduction applies without regard to whether a waiver under subparagraph (A) has been approved with respect to such balance); and

(II) the grant funds involved in such reduction shall be made available by the Secretary as additional funds for grants pursuant to subsection (b) for such first fiscal year, subject to subsection (a)(4) and section 2610(d)(2);

except that this clause does not apply to the eligible area if the amount of the unobligated balance was 2 percent or less.

(ii) RELATION TO INCREASES IN GRANT.—A reduction under clause (i) for an eligible area for a fiscal year may not be taken into account in applying subsection (a)(4) with respect to the area for the subsequent fiscal year.

[(c)**]** *(d)* COMPLIANCE WITH PRIORITIES OF HIV PLANNING COUNCIL.—Notwithstanding any other provision of **[**this part**]** *this subpart*, the Secretary, in carrying out section 2601(a), may not make any grant under subsection (a) or (b) to an eligible area unless the application submitted by such area under section 2605 for the grant involved demonstrates that the grants made under subsections (a) and (b) to the area for the preceding fiscal year (if any) were expended in accordance with the priorities applicable to such

year that were established, pursuant to section 2602(b)(4)(C), by the planning council serving the area.

[SEC. 2604. USE OF AMOUNTS.

[(a) REQUIREMENTS.—The Secretary may not make a grant under section 2601(a) to the chief elected official of an eligible area unless such political subdivision agrees that—

[(1) subject to paragraph (2), the allocation of funds and services within the eligible area will be made in accordance with the priorities established, pursuant to section 2602(b)(3)(A), by the HIV health services planning council that serves such eligible area; and

[(2) funds provided under section 2601 will be expended only for the purposes described in subsections (b) and (c).

[(b) PRIMARY PURPOSES.—

[(1) IN GENERAL.—The chief elected official shall use amounts received under a grant under section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of delivering or enhancing HIV-related services, as follows:

[(A) Outpatient and ambulatory health services, including substance abuse treatment, mental health treatment, and comprehensive treatment services, which shall include treatment education and prophylactic treatment for opportunistic infections, for individuals and families with HIV disease.

[(B) Outpatient and ambulatory support services (including case management), to the extent that such services facilitate, enhance, support, or sustain the delivery, continuity, or benefits of health services for individuals and families with HIV disease.

[(C) Inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities.

[(D) Outreach activities that are intended to identify individuals with HIV disease who know their HIV status and are not receiving HIV-related services, and that are—

[(i) necessary to implement the strategy under section 2602(b)(4)(D), including activities facilitating the access of such individuals to HIV-related primary care services at entities described in paragraph (3)(A);

[(ii) conducted in a manner consistent with the requirements under sections 2605(a)(3) and 2651(b)(2); and

[(iii) supplement, and do not supplant, such activities that are carried out with amounts appropriated under section 317.

[(2) APPROPRIATE ENTITIES.—

[(A) IN GENERAL.—Subject to subparagraph (B), direct financial assistance may be provided under paragraph (1) to public or nonprofit private entities,, or private for-profit entities if such entities are the only available provider of quality HIV care in the area, including hospitals (which may include Department of Veterans Affairs facilities), community-based organizations, hospices, ambulatory care facilities, community health centers, migrant health cen-

ters, homeless health centers, substance abuse treatment programs, and mental health programs.

[(B) PRIORITY.—In providing direct financial assistance under paragraph (1) the chief elected official shall give priority to entities that are currently participating in Health Resources and Services Administration HIV health care demonstration projects.

[(3) EARLY INTERVENTION SERVICES.—

[(A) IN GENERAL.—The purposes for which a grant under section 2601 may be used include providing to individuals with HIV disease early intervention services described in section 2651(b)(2), with follow-up referral provided for the purpose of facilitating the access of individuals receiving the services to HIV-related health services. The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV disease counseling and testing sites, health care points of entry specified by eligible areas, federally qualified health centers, and entities described in section 2652(a) that constitute a point of access to services by maintaining referral relationships.

[(B) CONDITIONS.—With respect to an entity that proposes to provide early intervention services under subparagraph (A), such subparagraph applies only if the entity demonstrates to the satisfaction of the chief elected official for the eligible area involved that—

[(i) Federal, State, or local funds are otherwise inadequate for the early intervention services the entity proposes to provide; and

[(ii) the entity will expend funds pursuant to such subparagraph to supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved.

[(4) PRIORITY FOR WOMEN, INFANTS AND CHILDREN.—

[(A) IN GENERAL.—For the purpose of providing health and support services to infants, children, youth, and women with HIV disease, including treatment measures to prevent the perinatal transmission of HIV, the chief elected official of an eligible area, in accordance with the established priorities of the planning council, shall for each of such populations in the eligible area use, from the grants made for the area under section 2601(a) for a fiscal year, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with acquired immune deficiency syndrome to the general population in such area of individuals with such syndrome.

[(B) WAIVER.—With respect to the population involved, the Secretary may provide to the chief elected official of an eligible area a waiver of the requirement of subparagraph (A) if such official demonstrates to the satisfaction of the Secretary that the population is receiving HIV-related

health services through the State medicaid program under title XIX of the Social Security Act, the State children's health insurance program under title XXI of such Act, or other Federal or State programs.

[(c) QUALITY MANAGEMENT.—

[(1) REQUIREMENT.—The chief elected official of an eligible area that receives a grant under this part shall provide for the establishment of a quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

[(2) USE OF FUNDS.—From amounts received under a grant awarded under this part for a fiscal year, the chief elected official of an eligible area may (in addition to amounts to which subsection (f)(1) applies) use for activities associated with the quality management program required in paragraph (1) not more than the lesser of—

[(A) 5 percent of amounts received under the grant; or

[(B) $3,000,000.

[(d) LIMITED EXPENDITURES FOR PERSONNEL NEEDS.—

[(1) IN GENERAL.—A chief elected official, in accordance with paragraph (3), may use not to exceed 10 percent of amounts received under a grant under section 2601 to provide financial assistance or services, for the purposes described in paragraph (2), to any public or nonprofit private entity, including hospitals (which may include Veterans Administration facilities), nursing homes, subacute and transitional care facilities, and hospices that—

[(A) provide HIV-related care or services to a disproportionate share of low-income individuals and families with HIV disease;

[(B) incur uncompensated costs in the provision of such care or services to such individuals and families;

[(C) have established, and agree to implement, a plan to evaluate the utilization of services provided in the care of individuals and families with HIV disease; and

[(D) have established a system designed to ensure that such individuals and families are referred to the most medically appropriate level of care as soon as such referral is medically indicated.

[(2) USE.—A chief elected official may use amounts referred to in paragraph (1) to—

[(A) provide direct financial assistance to institutions and entities of the type referred to in such paragraph to assist such institutions and entities in recruiting or training and paying compensation to qualified personnel determined, under paragraph (3), to be necessary by the HIV health services planning council, specifically for the care of individuals with HIV disease; or

[(B) in lieu of providing direct financial assistance, make arrangements for the provision of the services of such qualified personnel to such institutions and entities.

[(3) REQUIREMENT OF DETERMINATION BY COUNCIL.—A chief elected official shall not use any of the amounts received under a grant under section 2601(a) to provide assistance or services under paragraph (2) unless the HIV health services planning council of the eligible area has made a determination that, with respect to the care of individuals with HIV disease—

[(A) a shortage of specific health, mental health or support service personnel exists within specific institutions or entities in the eligible area;

[(B) the shortage of such personnel has resulted in the inappropriate utilization of inpatient services within the area; and

[(C) assistance or services provided to an institution or entity under paragraph (2), will not be used to supplant the existing resources devoted by such institution or entity to the uses described in such paragraph.

[(e) REQUIREMENT OF STATUS AS MEDICAID PROVIDER.—

[(1) PROVISION OF SERVICE.—Subject to paragraph (2), the Secretary may not make a grant under section 2601(a) for the provision of services under this section in a State unless, in the case of any such service that is available pursuant to the State plan approved under title XIX of the Social Security Act for the State—

[(A) the political subdivision involved will provide the service directly, and the political subdivision has entered into a participation agreement under the State plan and is qualified to receive payments under such plan; or

[(B) the political subdivision will enter into an agreement with a public or nonprofit private entity under which the entity will provide the service, and the entity has entered into such a participation agreement and is qualified to receive such payments.

[(2) WAIVER.—

[(A) IN GENERAL.—In the case of an entity making an agreement pursuant to paragraph (1)(B) regarding the provision of services, the requirement established in such paragraph shall be waived by the HIV health services planning council for the eligible area if the entity does not, in providing health care services, impose a charge or accept reimbursement available from any third-party payor, including reimbursement under any insurance policy or under any Federal or State health benefits program.

[(B) DETERMINATION.—A determination by the HIV health services planning council of whether an entity referred to in subparagraph (A) meets the criteria for a waiver under such subparagraph shall be made without regard to whether the entity accepts voluntary donations for the purpose of providing services to the public.

[(f) ADMINISTRATION.—

[(1) IN GENERAL.—The chief executive officer of an eligible area shall not use in excess of 5 percent of amounts received under a grant awarded under this part for administration,. In

the case of entities and subcontractors to which such officer allocates amounts received by the officer under the grant, the officer shall ensure that, of the aggregate amount so allocated, the total of the expenditures by such entities for administrative expenses does not exceed 10 percent (without regard to whether particular entities expend more than 10 percent for such expenses).

[(2) ADMINISTRATIVE ACTIVITIES.—For the purposes of paragraph (1), amounts may be used for administrative activities that include—

[(A) routine grant administration and monitoring activities, including the development of applications for part A funds, the receipt and disbursal of program funds, the development and establishment of reimbursement and accounting systems, the preparation of routine programmatic and financial reports, and compliance with grant conditions and audit requirements; and

[(B) all activities associated with the grantee's contract award procedures, including the development of requests for proposals, contract proposal review activities, negotiation and awarding of contracts, monitoring of contracts through telephone consultation, written documentation or onsite visits, reporting on contracts, and funding reallocation activities.

[(3) SUBCONTRACTOR ADMINISTRATIVE COSTS.—For the purposes of this subsection, subcontractor administrative activities include—

[(A) usual and recognized overhead, including established indirect rates for agencies;

[(B) management oversight of specific programs funded under this title; and

[(C) other types of program support such as quality assurance, quality control, and related activities.

[(g) CONSTRUCTION.—A State may not use amounts received under a grant awarded under this part to purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or to make cash payments to intended recipients of services.]

SEC. 2604. USE OF AMOUNTS.

(a) REQUIREMENTS.—The Secretary may not make a grant under section 2601(a) to the chief elected official of an eligible area unless such political subdivision agrees that—

(1) subject to paragraph (2), the allocation of funds and services within the eligible area will be made in accordance with the priorities established, pursuant to section 2602(b)(4)(C), by the HIV health services planning council that serves such eligible area;

(2) funds provided under section 2601 will be expended only for—

(A) core medical services described in subsection (c);

(B) support services described in subsection (d); and

(C) administrative expenses described in subsection (h); and

(3) the use of such funds will comply with the requirements of this section.

(b) DIRECT FINANCIAL ASSISTANCE TO APPROPRIATE ENTITIES.—

(1) IN GENERAL.—The chief elected official of an eligible area shall use amounts from a grant under section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of providing core medical services and support services.

(2) APPROPRIATE ENTITIES.—Direct financial assistance may be provided under paragraph (1) to public or nonprofit private entities, or private for-profit entities if such entities are the only available provider of quality HIV care in the area.

(c) REQUIRED FUNDING FOR CORE MEDICAL SERVICES.—

(1) IN GENERAL.—With respect to a grant under section 2601 for an eligible area for a grant year, the chief elected official of the area shall, of the portion of the grant remaining after reserving amounts for purposes of paragraphs (1) and (5)(B)(i) of subsection (h), use not less than 75 percent to provide core medical services that are needed in the eligible area for individuals with HIV/AIDS who are identified and eligible under this title (including services regarding the co-occurring conditions of the individuals).

(2) WAIVER.—

(A) IN GENERAL.—The Secretary shall waive the application of paragraph (1) with respect to a chief elected official for a grant year if the Secretary determines that, within the eligible area involved—

(i) there are no waiting lists for AIDS Drug Assistance Program services under section 2616; and

(ii) core medical services are available to all individuals with HIV/AIDS identified and eligible under this title.

(B) NOTIFICATION OF WAIVER STATUS.—When informing the chief elected official of an eligible area that a grant under section 2601 is being made for the area for a grant year, the Secretary shall inform the official whether a waiver under subparagraph (A) is in effect for such year.

(3) CORE MEDICAL SERVICES.—For purposes of this subsection, the term "core medical services", with respect to an individual with HIV/AIDS (including the co-occurring conditions of the individual), means the following services:

(A) Outpatient and ambulatory health services.

(B) AIDS Drug Assistance Program treatments in accordance with section 2616.

(C) AIDS pharmaceutical assistance.

(D) Oral health care.

(E) Early intervention services described in subsection (e).

(F) Health insurance premium and cost sharing assistance for low-income individuals in accordance with section 2615.

(G) Home health care.

(H) Medical nutrition therapy.

(I) Hospice services.

(J) Home and community-based health services as defined under section 2614(c).

(K) Mental health services.

(L) Substance abuse outpatient care.

(M) Medical case management, including treatment adherence services.

(d) SUPPORT SERVICES.—

(1) IN GENERAL.—For purposes of this section, the term "support services" means services, subject to the approval of the Secretary, that are needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services).

(2) MEDICAL OUTCOMES.—In this subsection, the term "medical outcomes" means those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

(e) EARLY INTERVENTION SERVICES.—

(1) IN GENERAL.—For purposes of this section, the term "early intervention services" means HIV/AIDS early intervention services described in section 2651(e), with follow-up referral provided for the purpose of facilitating the access of individuals receiving the services to HIV-related health services. The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV/AIDS counseling and testing sites, health care points of entry specified by eligible areas, federally qualified health centers, and entities described in section 2652(a) that constitute a point of access to services by maintaining referral relationships.

(2) CONDITIONS.—With respect to an entity that proposes to provide early intervention services under paragraph (1), such paragraph shall apply only if the entity demonstrates to the satisfaction of the chief elected official for the eligible area involved that—

(A) Federal, State, or local funds are otherwise inadequate for the early intervention services the entity proposes to provide; and

(B) the entity will expend funds pursuant to such paragraph to supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved.

(f) PRIORITY FOR WOMEN, INFANTS, CHILDREN, AND YOUTH.—

(1) IN GENERAL.—For the purpose of providing health and support services to infants, children, youth, and women with HIV/AIDS, including treatment measures to prevent the perinatal transmission of HIV, the chief elected official of an eligible area, in accordance with the established priorities of the planning council, shall for each of such populations in the eligible area use, from the grants made for the area under section 2601(a) for a fiscal year, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS.

(2) WAIVER.—With respect to the population involved, the Secretary may provide to the chief elected official of an eligible area a waiver of the requirement of paragraph (1) if such offi-

cial demonstrates to the satisfaction of the Secretary that the population is receiving HIV-related health services through the State medicaid program under title XIX of the Social Security Act, the State children's health insurance program under title XXI of such Act, or other Federal or State programs.

(g) REQUIREMENT OF STATUS AS MEDICAID PROVIDER.—

(1) PROVISION OF SERVICE.—Subject to paragraph (2), the Secretary may not make a grant under section 2601(a) for the provision of services under this section in a State unless, in the case of any such service that is available pursuant to the State plan approved under title XIX of the Social Security Act for the State—

(A) the political subdivision involved will provide the service directly, and the political subdivision has entered into a participation agreement under the State plan and is qualified to receive payments under such plan; or

(B) the political subdivision will enter into an agreement with a public or nonprofit private entity under which the entity will provide the service, and the entity has entered into such a participation agreement and is qualified to receive such payments.

(2) WAIVER.—

(A) IN GENERAL.—In the case of an entity making an agreement pursuant to paragraph (1)(B) regarding the provision of services, the requirement established in such paragraph shall be waived by the HIV health services planning council for the eligible area if the entity does not, in providing health care services, impose a charge or accept reimbursement available from any third-party payor, including reimbursement under any insurance policy or under any Federal or State health benefits program.

(B) DETERMINATION.—A determination by the HIV health services planning council of whether an entity referred to in subparagraph (A) meets the criteria for a waiver under such subparagraph shall be made without regard to whether the entity accepts voluntary donations for the purpose of providing services to the public.

(h) ADMINISTRATION.—

(1) LIMITATION.—The chief executive officer of an eligible area shall not use in excess of 10 percent of amounts received under a grant under this part for administrative expenses.

(2) ALLOCATIONS BY CHIEF EXECUTIVE OFFICER.—In the case of entities and subcontractors to which the chief executive officer of an eligible area allocates amounts received by the officer under a grant under this part, the officer shall ensure that, of the aggregate amount so allocated, the total of the expenditures by such entities for administrative expenses does not exceed 10 percent (without regard to whether particular entities expend more than 10 percent for such expenses).

(3) ADMINISTRATIVE ACTIVITIES.—For purposes of paragraph (1), amounts may be used for administrative activities that include—

(A) routine grant administration and monitoring activities, including the development of applications for part A funds, the receipt and disbursal of program funds, the de-

velopment and establishment of reimbursement and accounting systems, the development of a clinical quality management program as described in paragraph (5), the preparation of routine programmatic and financial reports, and compliance with grant conditions and audit requirements; and

(B) all activities associated with the grantee's contract award procedures, including the activities carried out by the HIV health services planning council as established under section 2602(b), the development of requests for proposals, contract proposal review activities, negotiation and awarding of contracts, monitoring of contracts through telephone consultation, written documentation or onsite visits, reporting on contracts, and funding reallocation activities.

(4) SUBCONTRACTOR ADMINISTRATIVE ACTIVITIES.—For the purposes of this subsection, subcontractor administrative activities include—

(A) usual and recognized overhead activities, including established indirect rates for agencies;

(B) management oversight of specific programs funded under this title; and

(C) other types of program support such as quality assurance, quality control, and related activities.

(5) CLINICAL QUALITY MANAGEMENT.—

(A) REQUIREMENT.—The chief elected official of an eligible area that receives a grant under this part shall provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

(B) USE OF FUNDS.—

(i) IN GENERAL.—From amounts received under a grant awarded under this subpart for a fiscal year, the chief elected official of an eligible area may use for activities associated with the clinical quality management program required in subparagraph (A) not to exceed the lesser of—

(I) 5 percent of amounts received under the grant; or

(II) $3,000,000.

(ii) RELATION TO LIMITATION ON ADMINISTRATIVE EXPENSES.—The costs of a clinical quality management program under subparagraph (A) may not be considered administrative expenses for purposes of the limitation established in paragraph (1).

(i) CONSTRUCTION.—A chief elected official may not use amounts received under a grant awarded under this part to purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or to make cash payments to intended recipients of services.

SEC. 2605. APPLICATION.

(a) IN GENERAL.—To be eligible to receive a grant under section 2601, an eligible area shall prepare and submit to the Secretary an application, in accordance with subsection (c) regarding a single application and grant award, at such time, in such form, and containing such information as the Secretary shall require, including assurances adequate to ensure—

(1)(A) that funds received under a grant awarded under [this part] *this subpart* will be utilized to supplement not supplant State funds made available in the year for which the grant is awarded to provide HIV-related services as described in section 2604(b)(1);

* * * * * * *

(C) that political subdivisions within the eligible area will not use funds received under a grant awarded under [this part] *this subpart* in maintaining the level of expenditures for HIV-related services as required in subparagraph (B);

* * * * * * *

(3) that entities within the eligible area that receive funds under a grant under [this part] *this subpart* will maintain appropriate relationships with entities in the eligible area served that constitute key points of access to the health care system for individuals with HIV disease (including emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, sexually transmitted disease clinics, HIV counseling and testing sites, mental health programs, and homeless shelters), and other entities under section 2604(b)(3) and 2652(a), for the purpose of facilitating early intervention for individuals newly diagnosed with HIV disease and individuals knowledgeable of their HIV status but not in care;

* * * * * * *

(6) that funds received under a grant awarded under [this part] *this subpart* will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service—

(A) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program *(except for a program administered by or providing the services of the Indian Health Service)*; or

* * * * * * *

(7) to the maximum extent practicable, that—

(A) HIV health care and support services provided with assistance made available under [this part] *this subpart* will be provided without regard—

(i) * * *

* * * * * * *

(8) that the applicant has participated, or will agree to participate, in the statewide coordinated statement of need process where it has been initiated by the State public health agency responsible for administering grants under part B, and ensure

that the services provided under the comprehensive plan are consistent with the statewide coordinated statement of need; [and]

(9) that the eligible area has procedures in place to ensure that services provided with funds received under this part meet the criteria specified in section 2604(b)(1)[.]*; and*

(10) that the chief elected official will submit to the lead State agency under section 2617(b)(4), audits, consistent with Office of Management and Budget circular A133, regarding funds expended in accordance with this part every 2 years and shall include necessary client-based data to compile unmet need calculations and Statewide coordinated statements of need process.

(b) APPLICATION.—An eligible area that desires to receive a grant under section 2603(b) shall prepare and submit to the Secretary an application, in accordance with subsection (c) regarding a single application and grant award, at such time, in such form, and containing such information as the Secretary shall require, including the information required under such subsection and information concerning

(1) * * *

* * * * * * *

(3) the average cost of providing each category of HIV-related health services and the extent to which such cost is paid by third-party payors; [and]

(4) the aggregate amounts expended for each such category of services[.]*;*

(5) the manner in which the expected expenditures are related to the planning process for States that receive funding under part B (including the planning process described in section 2617(b)); and

(6) the expected expenditures and how those expenditures will improve overall client outcomes, as described under the State plan under section 2617(b), and through additional outcomes measures as identified by the HIV health services planning council under section 2602(b).

* * * * * * *

(d) DATE CERTAIN FOR SUBMISSION.—

(1) * * *

* * * * * * *

(4) REDISTRIBUTION.—Any amounts appropriated in any fiscal year under [this part] *this subpart* and not obligated to an eligible entity as a result of the failure of such entity to submit an application shall be redistributed by the Secretary to other eligible entities in proportion to the original grants made to such eligible areas under section 2601(a).

(e) REQUIREMENTS REGARDING IMPOSITION OF CHARGES FOR SERVICES.—

(1) * * *

* * * * * * *

(2) ASSESSMENT OF CHARGE.—With respect to compliance with the assurance made under paragraph (1), a grantee or entity receiving assistance under [this part] *this subpart* may, in

the case of individuals subject to a charge for purposes of such paragraph—

(A) * * *

* * * * * * *

SEC. 2606. TECHNICAL ASSISTANCE.

The Administrator of the Health Resources and Services Administration shall, beginning on the date of enactment of this title, provide technical assistance, including assistance from other grantees, contractors or subcontractors under this title to assist newly eligible metropolitan areas in the establishment of HIV health services planning councils and, to assist entities in complying with the requirements of [this part] *this subpart* in order to make such entities eligible to receive a grant under [this part] *this subpart*. The Administrator may make planning grants available to metropolitan areas, in an amount not to exceed $75,000 for any metropolitan area, projected to be eligible for funding under section 2601 in the following fiscal year. Such grant amounts shall be deducted from the first year formula award to eligible areas accepting such grants. Not to exceed 1 percent of the amount appropriated for a fiscal year under section 2677 for grants under part A may be used to carry out this section.

SEC. 2607. DEFINITIONS.

For purposes of [this part] *this subpart*:

(1) * * *

(2) METROPOLITAN AREA.—The term "metropolitan area" means an [area referred] *area that is referred* to in the HIV/AIDS Surveillance Report of the Centers for Disease Control and Prevention as a metropolitan area*, and that has a population of 50,000 or more individuals*.

Subpart II—Transitional Grants

SEC. 2609. ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall make grants for the purpose of providing services described in section 2604 in transitional areas, subject to the same provisions regarding the allocation of grant funds as apply under subsection (c) of such section.

(b) TRANSITIONAL AREAS.—For purposes of this section, the term "transitional area" means, subject to subsection (c), a metropolitan area for which there has been reported to and confirmed by the Director of the Centers for Disease Control and Prevention a cumulative total of at least 1,000, but fewer than 2,000, cases of AIDS during the most recent period of 5 calendar years for which such data are available.

(c) CERTAIN ELIGIBILITY RULES.—

(1) FISCAL YEAR 2007.—With respect to grants under subsection (a) for fiscal year 2007, a metropolitan area that received funding under subpart I for fiscal year 2006 but does not for fiscal year 2007 qualify under such subpart as an eligible area and does not qualify under subsection (b) as a transitional

area shall, notwithstanding subsection (b), be considered a transitional area.

(2) CONTINUED STATUS AS TRANSITIONAL AREA.—

(A) IN GENERAL.—Notwithstanding subsection (b), a metropolitan area that is a transitional area for a fiscal year continues, except as provided in subparagraph (B), to be a transitional area until the metropolitan area fails, for three consecutive fiscal years—

(i) to qualify under such subsection as a transitional area; and

(ii) to have a cumulative total of 1,500 or more living cases of AIDS (reported to and confirmed by the Director of the Centers for Disease Control and Prevention) as of December 31 of the most recent calendar year for which such data is available.

(B) EXCEPTION REGARDING STATUS AS ELIGIBLE AREA.—Subparagraph (A) does not apply for a fiscal year if the metropolitan area involved qualifies under subpart I as an eligible area.

(d) APPLICATION OF CERTAIN PROVISIONS OF SUBPART I.—

(1) ADMINISTRATION; PLANNING COUNCIL.—

(A) IN GENERAL.—The provisions of section 2602 apply with respect to a grant under subsection (a) for a transitional area to the same extent and in the same manner as such provisions apply with respect to a grant under subpart I for an eligible area, except that, subject to subparagraph (B), the chief elected official of the transitional area may elect not to comply with the provisions of section 2602(b) if the official provides documentation to the Secretary that details the process used to obtain community input (particularly from those with HIV) in the transitional area for formulating the overall plan for priority setting and allocating funds from the grant under subsection (a).

(B) EXCEPTION.—For each of the fiscal years 2007 through 2009, the exception described in subparagraph (A) does not apply if the transitional area involved received funding under subpart I for fiscal year 2006.

(2) TYPE AND DISTRIBUTION OF GRANTS; TIMEFRAME FOR OBLIGATION AND EXPENDITURE OF GRANT FUNDS.—

(A) FORMULA GRANTS; SUPPLEMENTAL GRANTS.—The provisions of section 2603 apply with respect to grants under subsection (a) to the same extent and in the same manner as such provisions apply with respect to grants under subpart I, subject to subparagraphs (B) and (C).

(B) FORMULA GRANTS; INCREASE IN GRANT.—For purposes of subparagraph (A), section 2603(a)(4) does not apply.

(C) SUPPLEMENTAL GRANTS; SINGLE PROGRAM WITH SUBPART I PROGRAM.—With respect to section 2603(b) as applied for purposes of subparagraph (A):

(i) The Secretary shall combine amounts available pursuant to such subparagraph with amounts available for carrying out section 2603(b) and shall administer the two programs as a single program.

(ii) In the single program, the Secretary has discretion in allocating amounts between eligible areas under subpart I and transitional areas under this section, subject to the eligibility criteria that apply under such section, and subject to section 2603(b)(2)(C) (relating to priority in making grants).

(iii) Pursuant to section 2603(b)(1), amounts for the single program are subject to use under sections 2603(a)(4) and 2610(d)(1).

(3) APPLICATION; TECHNICAL ASSISTANCE; DEFINITIONS.—The provisions of sections 2605, 2606, and 2607 apply with respect to grants under subsection (a) to the same extent and in the same manner as such provisions apply with respect to grants under subpart I.

Subpart III—General Provisions

SEC. 2610. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—For the purpose of carrying out this part, there are authorized to be appropriated $604,000,000 for fiscal year 2007, $626,300,000 for fiscal year 2008, $649,500,000 for fiscal year 2009, $673,600,000 for fiscal year 2010, and $698,500,000 for fiscal year 2011. Amounts appropriated under the preceding sentence for a fiscal year are available for obligation by the Secretary until the end of the second succeeding fiscal year.

(b) RESERVATION OF AMOUNTS.—

(1) FISCAL YEAR 2007.—Of the amount appropriated under subsection (a) for fiscal year 2007, the Secretary shall reserve—

(A) $458,310,000 for grants under subpart I; and

(B) $145,690,000 for grants under section 2609.

(2) SUBSEQUENT FISCAL YEARS.—Of the amount appropriated under subsection (a) for fiscal year 2008 and each subsequent fiscal year—

(A) the Secretary shall reserve an amount for grants under subpart I; and

(B) the Secretary shall reserve an amount for grants under section 2609.

(c) TRANSFER OF CERTAIN AMOUNTS; CHANGE IN STATUS AS ELIGIBLE AREA OR TRANSITIONAL AREA.—Notwithstanding subsection (b):

(1) If a metropolitan area is an eligible area under subpart I for a fiscal year, but for a subsequent fiscal year ceases to be an eligible area by reason of section 2601(b)—

(A)(i) the amount reserved under paragraph (1)(A) or (2)(A) of subsection (b) of this section for the first such subsequent year of not being an eligible area is deemed to be reduced by an amount equal to the amount of the grant made pursuant to section 2603(a) for the metropolitan area for the preceding fiscal year; and

(ii)(I) if the metropolitan area qualifies for such first subsequent fiscal year as a transitional area under 2609, the amount reserved under paragraph (1)(B) or (2)(B) of subsection (b) for such fiscal year is deemed to be increased by an amount equal to the amount of the reduction under subparagraph (A) for such year; or

(II) if the metropolitan area does not qualify for such first subsequent fiscal year as a transitional area under 2609, an amount equal to the amount of such reduction is, notwithstanding subsection (a), transferred and made available for grants pursuant to section 2618(a)(1), in addition to amounts available for such grants under section 2623; and

(B) if a transfer under subparagraph (A)(ii)(II) is made with respect to the metropolitan area for such first subsequent fiscal year, then—

(i) the amount reserved under paragraph (1)(A) or (2)(A) of subsection (b) of this section for such year is deemed to be reduced by an additional $500,000; and

(ii) an amount equal to the amount of such additional reduction is, notwithstanding subsection (a), transferred and made available for grants pursuant to section 2618(a)(1), in addition to amounts available for such grants under section 2623.

(2) If a metropolitan area is a transitional area under section 2609 for a fiscal year, but for a subsequent fiscal year ceases to be a transitional area by reason of section 2609(c)(2) (and does not qualify for such subsequent fiscal year as an eligible area under subpart I)—

(A) the amount reserved under subsection (b)(2)(B) of this section for the first such subsequent fiscal year of not being a transitional area is deemed to be reduced by an amount equal to the total of—

(i) the amount of the grant that, pursuant to section 2603(a), was made under section 2609(d)(2)(A) for the metropolitan area for the preceding fiscal year; and

(ii) $500,000; and

(B) an amount equal to the amount of the reduction under subparagraph (A) for such year is, notwithstanding subsection (a), transferred and made available for grants pursuant to section 2618(a)(1), in addition to amounts available for such grants under section 2623.

(3) If a metropolitan area is a transitional area under section 2609 for a fiscal year, but for a subsequent fiscal year qualifies as an eligible area under subpart I—

(A) the amount reserved under subsection (b)(2)(B) of this section for the first such subsequent fiscal year of becoming an eligible area is deemed to be reduced by an amount equal to the amount of the grant that, pursuant to section 2603(a), was made under section 2609(d)(2)(A) for the metropolitan area for the preceding fiscal year; and

(B) the amount reserved under subsection (b)(2)(A) for such fiscal year is deemed to be increased by an amount equal to the amount of the reduction under subparagraph (A) for such year.

(d) CERTAIN TRANSFERS; ALLOCATIONS BETWEEN PROGRAMS UNDER SUBPART I.—With respect to paragraphs (1)(B)(i) and (2)(A)(ii) of subsection (c), the Secretary shall administer any reductions under such paragraphs for a fiscal year in accordance with the following:

(1) The reductions shall be made from amounts available for the single program referred to in section 2609(d)(2)(C) (relating to supplemental grants).

(2) The reductions shall be made before the amounts referred to in paragraph (1) are used for purposes of section 2603(a)(4).

(3) If the amounts referred to in paragraph (1) are not sufficient for making all the reductions, the reductions shall be reduced until the total amount of the reductions equals the total of the amounts referred to in such paragraph.

(e) RULES OF CONSTRUCTION REGARDING FIRST SUBSEQUENT FISCAL YEAR.—Paragraphs (1) and (2) of subsection (c) apply with respect to each series of fiscal years during which a metropolitan area is an eligible area under subpart I or a transitional area under section 2609 for a fiscal year and then for a subsequent fiscal year ceases to be such an area by reason of section 2601(b) or 2609(c)(2), respectively, rather than applying to a single such series. Paragraph (3) of subsection (c) applies with respect to each series of fiscal years during which a metropolitan area is a transitional area under section 2609 for a fiscal year and then for a subsequent fiscal year becomes an eligible area under subpart I, rather than applying to a single such series.

PART B—Care Grant Program

SUBPART I—GENERAL GRANT PROVISIONS

SEC. 2611. GRANTS.

[(a) IN GENERAL.—]The Secretary shall, subject to the availability of appropriations, make grants to States to enable such States to improve the quality, availability and organization of health care and support services for individuals and families with HIV disease. The authority of the Secretary to provide grants under part B is subject to section 2626(e)(2) (relating to the decrease in perinatal transmission of HIV disease).

[(b) PRIORITY FOR WOMEN, INFANTS AND CHILDREN.—

[(1) IN GENERAL.—For the purpose of providing health and support services to infants, children, youth, and women with HIV disease, including treatment measures to prevent the perinatal transmission of HIV, a State shall for each of such populations use, of the funds allocated under this part to the State for a fiscal year, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in the State) with acquired immune deficiency syndrome to the general population in the State of individuals with such syndrome.

[(2) WAIVER.—With respect to the population involved, the Secretary may provide to a State a waiver of the requirement of paragraph (1) if the State demonstrates to the satisfaction of the Secretary that the population is receiving HIV-related health services through the State medicaid program under title XIX of the Social Security Act, the State children's health insurance program under title XXI of such Act, or other Federal or State programs.]

[SEC. 2612. GENERAL USE OF GRANTS.

[(a) IN GENERAL.—A State may use amounts provided under grants made under this part—

[(1) to provide the services described in section 2604(b)(1) for individuals with HIV disease;

[(2) to establish and operate HIV care consortia within areas most affected by HIV disease that shall be designed to provide a comprehensive continuum of care to individuals and families with HIV disease in accordance with section 2613;

[(3) to provide home- and community-based care services for individuals with HIV disease in accordance with section 2614;

[(4) to provide assistance to assure the continuity of health insurance coverage for individuals with HIV disease in accordance with section 2615; and

[(5) to provide therapeutics to treat HIV disease to individuals with HIV disease in accordance with section 2616.

Services described in paragraph (1) shall be delivered through consortia designed as described in paragraph (2), where such consortia exist, unless the State demonstrates to the Secretary that delivery of such services would be more effective when other delivery mechanisms are used. In making a determination regarding the delivery of services, the State shall consult with appropriate representatives of service providers and recipients of services who would be affected by such determination, and shall include in its demonstration to the Secretary the findings of the State regarding such consultation.

[(b) SUPPORT SERVICES; OUTREACH.—The purposes for which a grant under this part may be used include delivering or enhancing the following:

[(1) Outpatient and ambulatory support services under section 2611(a) (including case management) to the extent that such services facilitate, enhance, support, or sustain the delivery, continuity, or benefits of health services for individuals and families with HIV disease.

[(2) Outreach activities that are intended to identify individuals with HIV disease who know their HIV status and are not receiving HIV-related services, and that are—

[(A) necessary to implement the strategy under section 2617(b)(4)(B), including activities facilitating the access of such individuals to HIV-related primary care services at entities described in subsection (c)(1);

[(B) conducted in a manner consistent with the requirement under section 2617(b)(6)(G) and 2651(b)(2); and

[(C) supplement, and do not supplant, such activities that are carried out with amounts appropriated under section 317.

[(c) EARLY INTERVENTION SERVICES.—

[(1) IN GENERAL.—The purposes for which a grant under this part may be used include providing to individuals with HIV disease early intervention services described in section 2651(b)(2), with follow-up referral provided for the purpose of facilitating the access of individuals receiving the services to HIV-related health services. The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental

health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV disease counseling and testing sites, health care points of entry specified by States or eligible areas, federally qualified health centers, and entities described in section 2652(a) that constitute a point of access to services by maintaining referral relationships.

[(2) CONDITIONS.—With respect to an entity that proposes to provide early intervention services under paragraph (1), such paragraph applies only if the entity demonstrates to the satisfaction of the State involved that—

[(A) Federal, State, or local funds are otherwise inadequate for the early intervention services the entity proposes to provide; and

[(B) the entity will expend funds pursuant to such paragraph to supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved.

[(d) QUALITY MANAGEMENT.—

[(1) REQUIREMENT.—Each State that receives a grant under this part shall provide for the establishment of a quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

[(2) USE OF FUNDS.—From amounts received under a grant awarded under this part for a fiscal year, the State may (in addition to amounts to which section 2618(b)(5) applies) use for activities associated with the quality management program required in paragraph (1) not more than the lesser of—

[(A) 5 percent of amounts received under the grant; or

[(B) $3,000,000.]

SEC. 2612. GENERAL USE OF GRANTS.

(a) IN GENERAL.—A State may use amounts provided under grants made under section 2611 for—

(1) core medical services described in subsection (b);

(2) support services described in subsection (c); and

(3) administrative expenses described in section 2618(b)(3).

(b) REQUIRED FUNDING FOR CORE MEDICAL SERVICES.—

(1) IN GENERAL.—With respect to a grant under section 2611 for a State for a grant year, the State shall, of the portion of the grant remaining after reserving amounts for purposes of subparagraphs (A) and (E)(ii)(I) of section 2618(b)(3), use not less than 75 percent to provide core medical services that are needed in the State for individuals with HIV/AIDS who are identified and eligible under this title (including services regarding the co-occurring conditions of the individuals).

(2) WAIVER.—

(A) IN GENERAL.—The Secretary shall waive the application of paragraph (1) with respect to a State for a grant year if the Secretary determines that, within the State—

(i) there are no waiting lists for AIDS Drug Assistance Program services under section 2616; and

(ii) core medical services are available to all individuals with HIV/AIDS identified and eligible under this title.

(B) NOTIFICATION OF WAIVER STATUS.—When informing a State that a grant under section 2611 is being made to the State for a fiscal year, the Secretary shall inform the State whether a waiver under subparagraph (A) is in effect for the fiscal year.

(3) CORE MEDICAL SERVICES.—For purposes of this subsection, the term "core medical services", with respect to an individual infected with HIV/AIDS (including the co-occurring conditions of the individual) means the following services:

(A) Outpatient and ambulatory health services.

(B) AIDS Drug Assistance Program treatments in accordance with section 2616.

(C) AIDS pharmaceutical assistance.

(D) Oral health care.

(E) Early intervention services described in subsection (d).

(F) Health insurance premium and cost sharing assistance for low-income individuals in accordance with section 2615.

(G) Home health care.

(H) Medical nutrition therapy.

(I) Hospice services.

(J) Home and community-based health services as defined under section 2614(c).

(K) Mental health services.

(L) Substance abuse outpatient care.

(M) Medical case management, including treatment adherence services.

(c) SUPPORT SERVICES.—

(1) IN GENERAL.—For purposes of this subsection, the term "support services" means services, subject to the approval of the Secretary, that are needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services).

(2) DEFINITION OF MEDICAL OUTCOMES.—In this subsection, the term "medical outcomes" means those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

(d) EARLY INTERVENTION SERVICES.—

(1) IN GENERAL.—For purposes of this section, the term "early intervention services" means HIV/AIDS early intervention services described in section 2651(e), with follow-up referral provided for the purpose of facilitating the access of individuals receiving the services to HIV-related health services. The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV/AIDS counseling and

testing sites, health care points of entry specified by States, federally qualified health centers, and entities described in section 2652(a) that constitute a point of access to services by maintaining referral relationships.

(2) CONDITIONS.—With respect to an entity that proposes to provide early intervention services under paragraph (1), such paragraph shall apply only if the entity demonstrates to the satisfaction of the chief elected official for the State involved that—

(A) Federal, State, or local funds are otherwise inadequate for the early intervention services the entity proposes to provide; and

(B) the entity will expend funds pursuant to such subparagraph to supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved.

(e) PRIORITY FOR WOMEN, INFANTS, CHILDREN, AND YOUTH.—

(1) IN GENERAL.—For the purpose of providing health and support services to infants, children, youth, and women with HIV/AIDS, including treatment measures to prevent the perinatal transmission of HIV, a State shall for each of such populations in the eligible area use, from the grants made for the area under section 2601(a) for a fiscal year, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS.

(2) WAIVER.—With respect to the population involved, the Secretary may provide to a State a waiver of the requirement of paragraph (1) if such State demonstrates to the satisfaction of the Secretary that the population is receiving HIV-related health services through the State medicaid program under title XIX of the Social Security Act, the State children's health insurance program under title XXI of such Act, or other Federal or State programs.

(f) CONSTRUCTION.—A State may not use amounts received under a grant awarded under section 2611 to purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or to make cash payments to intended recipients of services.

SEC. 2613. GRANTS TO ESTABLISH HIV CARE CONSORTIA.

(a) CONSORTIA.—A State [may use] *may, subject to subsection (f), use* amounts provided under a grant awarded under [this part] *section 2611* to provide assistance under [section 2612(a)(1)] *section 2612(a)* to an entity that—

(1) is an association of one or more public, and one or more nonprofit private, (or private for-profit providers or organizations if such entities are the only available providers of quality HIV care in the area) health care and support service providers and community based organizations operating within areas determined by the State to be most affected by [HIV disease] *HIV/AIDS*; and

(2) agrees to use such assistance for the planning, development and delivery, through the direct provision of services or through entering into agreements with other entities for the provision of such services, of comprehensive outpatient health

and support services for individuals with [HIV disease] *HIV/AIDS*, that may include—

(A) * * *

(B) essential support services such as transportation services, attendant care, homemaker services, day or respite care, benefits advocacy, advocacy services provided through public and nonprofit private entities, and services that are incidental to the provision of health care services for individuals with [HIV disease] *HIV/AIDS* including nutrition services, housing referral services, and child welfare and family services (including foster care and adoption services).

An entity or entities of the type described in this subsection shall hereinafter be referred to in this title as a "consortium" or "consortia".

(b) ASSURANCES.—

(1) REQUIREMENT.—To receive assistance from a State under subsection (a), an applicant consortium shall provide the State with assurances that—

(A) within any locality in which such consortium is to operate, the populations and subpopulations of individuals and families with [HIV disease] *HIV/AIDS* have been identified by the consortium, particularly those experiencing disparities in access and services and those who reside in historically underserved communities;

* * * * * * *

(c) APPLICATION.—

(1) IN GENERAL.—To receive assistance from the State under subsection (a), a consortium shall prepare and submit to the State, an application that—

(A) demonstrates that the consortium includes agencies and community-based organizations—

(i) with a record of service to populations and subpopulations with [HIV disease] *HIV/AIDS* requiring care within the community to be served; and

* * * * * * *

(B) demonstrates that the consortium has carried out an assessment of service needs within the geographic area to be served and, after consultation with the entities described in paragraph (2), has established a plan to ensure the delivery of services to meet such identified needs that shall include—

(i) * * *

* * * * * * *

(iv) assurances that the assessment of service needs and the planning of the delivery of services will include participation by individuals with [HIV disease] *HIV/AIDS*;

(C) demonstrates that adequate planning has occurred to meet the special needs of families with [HIV disease] *HIV/AIDS*, including family centered and youth centered care;

* * * * * * *

(2) CONSULTATION.—In establishing the plan required under paragraph (1)(B), the consortium shall consult with—

(A) * * *

(B) not less than one community-based organization that is organized solely for the purpose of providing HIV-related support services to individuals with [HIV disease] *HIV/AIDS*;

* * * * * * *

(d) DEFINITION.—As used in [this part] *section 2611*, the term "family centered care" means the system of services described in this section that is targeted specifically to the special needs of infants, children, women, and families. Family centered care shall be based on a partnership between parents, professionals, and the community designed to ensure an integrated, coordinated, culturally sensitive, and community-based continuum of care for children, women, and families with [HIV disease] *HIV/AIDS*.

* * * * * * *

(f) ALLOCATION OF FUNDS; TREATMENT AS SUPPORT SERVICES.—For purposes of the requirement of section 2612(b)(1), expenditures of grants under section 2611 for or through consortia under this section are deemed to be support services, not core medical services. The preceding sentence may not be construed as having any legal effect on the provisions of subsection (a) that relate to authorized expenditures of the grant.

SEC. 2614. GRANTS FOR HOME- AND COMMUNITY-BASED CARE.

(a) USES.—A State may use amounts provided under a grant awarded under [this part] *section 2611* to make grants under [section 2612(a)(2)] *section 2612(b)(3)(J)* to entities to—

(1) provide home- and community-based health services for individuals with [HIV disease] *HIV/AIDS* pursuant to written plans of care prepared by a case management team, that shall include appropriate health care professionals, in such State for providing such services to such individuals;

(2) provide outreach services to individuals with [HIV disease] *HIV/AIDS*, including those individuals in rural areas; and

(3) provide for the coordination of the provision of services under this section with the provision of HIV-related health services*, including specialty care and vaccinations for hepatitis co-infection,* provided by public and private entities.

(b) PRIORITY.—In awarding grants under subsection (a), a State shall give priority to entities that provide assurances to the State that—

(1) * * *

(2) such entities will utilize amounts provided under such grants for the provision of home- and community-based services to low-income individuals with [HIV disease] *HIV/AIDS*.

(c) DEFINITION.—As used in [this part] *section 2611*, the term "home- and community-based health services"—

(1) means, with respect to an individual with [HIV disease] *HIV/AIDS*, skilled health services furnished to the individual in the individual's home pursuant to a written plan of care established by a case management team, that shall include ap-

propriate health care professionals, for the provision of such services and items described in paragraph (2);

(2) includes—

(A) * * *

(B) [homemaker or] home health aide services and personal care services furnished in the home of the individual;

* * * * * * *

SEC. 2615. CONTINUUM OF HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—A State may use amounts received under a grant awarded under [this part] *section 2611* to establish a program of financial assistance under section [2612(a)(3)] *2612(b)(3)(F)* to assist eligible low-income individuals with [HIV disease] *HIV/AIDS* in—

(1) * * *

* * * * * * *

SEC. 2616. PROVISION OF TREATMENTS.

(a) IN GENERAL.—A State shall use a portion of the amounts provided under a grant awarded under [this part] *section 2611* to establish a program under section [2612(a)(5)] *2612(b)(3)(B)* to provide therapeutics to treat [HIV disease] *HIV/AIDS* or prevent the serious deterioration of health arising from [HIV disease] *HIV/AIDS* in eligible individuals, including measures for the prevention and treatment of opportunistic infections.

(b) ELIGIBLE INDIVIDUAL.—To be eligible to receive assistance from a State under this section an individual shall—

(1) have a medical diagnosis of [HIV disease] *HIV/AIDS*; and

* * * * * * *

(c) STATE DUTIES.—In carrying out this section the State shall—

[(1) determine, in accordance with guidelines issued by the Secretary, which treatments are eligible to be included under the program established under this section;]

(1) ensure that the therapeutics included on the list of classes of core antiretroviral therapeutics established by the Secretary under subsection (e) are, at a minimum, the treatments provided by the State pursuant to this section;

* * * * * * *

(3) provide outreach to individuals with [HIV disease] *HIV/AIDS*, and as appropriate to the families of such individuals;

* * * * * * *

(e) LIST OF CLASSES OF CORE ANTIRETROVIRAL THERAPEUTICS.—For purposes of subsection (c)(1), the Secretary shall develop and maintain a list of classes of core antiretroviral therapeutics, which list shall be based on the therapeutics included in the guidelines of the Secretary known as the Clinical Practice Guidelines for Use of HIV/AIDS Drugs, relating to drugs needed to manage symptoms associated with HIV. The preceding sentence does not affect the authority of the Secretary to modify such Guidelines.

[(e)] *(f)* USE OF HEALTH INSURANCE AND PLANS.—

(1) IN GENERAL.—In carrying out subsection (a), a State may expend a grant under [this part] *section 2611* to provide the therapeutics described in such subsection by paying on behalf

of individuals with [HIV disease] *HIV/AIDS* the costs of purchasing or maintaining health insurance or plans whose coverage includes a full range of such therapeutics and appropriate primary care services.

(2) LIMITATION.—The authority established in paragraph (1) applies only to the extent that, for the fiscal year involved, the costs of the health insurance or plans to be purchased or maintained under such paragraph do not exceed the costs of otherwise providing therapeutics described in subsection (a).

(g) DRUG REBATE PROGRAM.—A State shall ensure that any drug rebates received on drugs purchased from funds provided pursuant to this section are applied to activities supported under this subpart, with priority given to activities described under this section.

SEC. 2617. STATE APPLICATION.

(a) IN GENERAL.—The Secretary shall not make a grant to a State under this part for a fiscal year unless the State prepares and submits, to the Secretary, an application at such time, in such form, and containing such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

(b) DESCRIPTION OF INTENDED USES AND AGREEMENTS.—The application submitted under subsection (a) shall contain—

(1) a detailed description of the HIV-related services provided in the State to individuals and families with [HIV disease] *HIV/AIDS* during the year preceding the year for which the grant is requested, and the number of individuals and families receiving such services, that shall include—

(A) a description of the types of programs operated or funded by the State for the provision of HIV-related services during the year preceding the year for which the grant is requested and the methods utilized by the State to finance such programs;

(B) an accounting of the amount of funds that the State has expended for such services and programs during the year preceding the year for which the grant is requested; and

(C) information concerning—

(i) the number of individuals to be served with assistance provided under the grant;

(ii) demographic data on the population of the individuals to be served;

(iii) the average cost of providing each category of HIV-related health services and the extent to which such cost is paid by third-party payors; and

(iv) the aggregate amounts expended for each such category of services;

(2) a determination of the size and demographics of the population of individuals with [HIV disease] *HIV/AIDS* in the State;

(3) a determination of the needs of such population, with particular attention to—

(A) individuals with [HIV disease] *HIV/AIDS* who know their HIV status and are not receiving HIV-related services; and

(B) disparities in access and services among affected subpopulations and historically underserved communities;

(4) the designation of a lead State agency that shall—

(A) administer all assistance received under this part;

(B) conduct the needs assessment and prepare the State plan under paragraph (3);

(C) prepare all applications for assistance under this part;

(D) receive notices with respect to programs under this title;

(E) every 2 years, collect and submit to the Secretary all audits, consistent with Office of Management and Budget circular A133, from grantees within the State, including audits regarding funds expended in accordance with this part; and

(F) carry out any other duties determined appropriate by the Secretary to facilitate the coordination of programs under this title.

[(4)**]** *(5)* a comprehensive plan that describes the organization and delivery of HIV health care and support services to be funded with assistance received under **[**this part**]** *section 2611* that shall include a description of the purposes for which the State intends to use such assistance, and that—

(A) establishes priorities for the allocation of funds within the State based on—

(i) size and demographics of the population of individuals with **[**HIV disease**]** *HIV/AIDS* (as determined under paragraph (2)) and the needs of such population (as determined under paragraph (3));

(ii) availability of other governmental and non-governmental resources, including the State medicaid plan under title XIX of the Social Security Act and the State Children's Health Insurance Program under title XXI of such Act to cover health care costs of eligible individuals and families with **[**HIV disease**]** *HIV/AIDS*;

(iii) capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities and rural communities; and

(iv) the efficiency of the administrative mechanism of the State for rapidly allocating funds to the areas of greatest need within the State;

(B) includes a strategy for identifying individuals who know their HIV status and are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable, and an appropriate allocation of funds;

(C) includes a strategy to coordinate the provision of such services with programs for HIV prevention (including outreach and early intervention) and for the prevention and treatment of substance abuse (including programs that provide comprehensive treatment services for such abuse);

(D) describes the services and activities to be provided and an explanation of the manner in which the elements of the program to be implemented by the State with such assistance will maximize the quality of health and support services available to individuals with [HIV disease] *HIV/AIDS* throughout the State;

(E) provides a description of the manner in which services funded with assistance provided under [this part] *section 2611* will be coordinated with other available related services for individuals with [HIV disease] *HIV/AIDS*; [and]

(F) provides a description of how the allocation and utilization of resources are consistent with the statewide coordinated statement of need (including traditionally underserved populations and subpopulations) developed in partnership with other grantees in the State that receive funding under this title; and

(G) includes key outcomes to be measured by all entities in the State receiving assistance under this title; and

[(5)] *(6)* an assurance that the public health agency administering the grant for the State will periodically convene a meeting of individuals with [HIV disease] *HIV/AIDS*, *members of a Federally recognized Indian tribe as represented in the State,* representatives of grantees under each part under this title, providers, and public agency representatives for the purpose of developing a statewide coordinated statement of need; and

[(6)] *(7)* an assurance by the State that—

(A) the public health agency that is administering the grant for the State engages in a public advisory planning process, including public hearings, that includes the participants under [paragraph (5)] *paragraph (6)*, and the types of entities described in section 2602(b)(2), in developing the comprehensive plan under [paragraph (4)] *paragraph (5)* and commenting on the implementation of such plan;

(B) the State will—

(i) to the maximum extent practicable, ensure that HIV-related health care and support services delivered pursuant to a program established with assistance provided under [this part] *section 2611* will be provided without regard to the ability of the individual to pay for such services and without regard to the current or past health condition of the individual with [HIV disease] *HIV/AIDS*;

(ii) ensure that such services will be provided in a setting that is accessible to low-income individuals with [HIV disease] *HIV/AIDS*;

(iii) provide outreach to low-income individuals with [HIV disease] *HIV/AIDS* to inform such individuals of the services available under [this part] *section 2611*; and

(iv) in the case of a State that intends to use amounts provided under the grant for purposes described in 2615, submit a plan to the Secretary that

demonstrates that the State has established a program that assures that—

(I) such amounts will be targeted to individuals who would not otherwise be able to afford health insurance coverage; and

(II) income, asset, and medical expense criteria will be established and applied by the State to identify those individuals who qualify for assistance under such program, and information concerning such criteria shall be made available to the public;

(C) the State will provide for periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the State under [this part] *section 2611*;

(D) the State will permit and cooperate with any Federal investigations undertaken regarding programs conducted under [this part] *section 2611*;

(E) the State will maintain HIV-related activities at a level that is equal to not less than the level of such expenditures by the State for the 1-year period preceding the fiscal year for which the State is applying to receive a grant under [this part] *section 2611*;

(F) the State will ensure that grant funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service—

(i) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

(ii) by an entity that provides health services on a prepaid basis *(except for a program administered by or providing the services of the Indian Health Service)*; and

(G) entities within areas in which activities under the grant are carried out will maintain appropriate relationships with entities in the area served that constitute key points of access to the health care system for individuals with [HIV disease] *HIV/AIDS* (including emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, sexually transmitted disease clinics, HIV counseling and testing sites, mental health programs, and homeless shelters), and other entities under section 2612(c) and 2652(a), for the purpose of facilitating early intervention for individuals newly diagnosed with [HIV disease] *HIV/AIDS* and individuals knowledgeable of their HIV status but not in care.

(c) REQUIREMENTS REGARDING IMPOSITION OF CHARGES FOR SERVICES.—

(1) IN GENERAL.—The Secretary may not make a grant under section 2611 to a State unless the State provides assurances that in the provision of services with assistance provided under the grant—

(A) in the case of individuals with an income less than or equal to 100 percent of the official poverty line, the pro-

vider will not impose charges on any such individual for the provision of services under the grant;

(B) in the case of individuals with an income greater than 100 percent of the official poverty line, the provider—

(i) will impose charges on each such individual for the provision of such services; and

(ii) will impose charges according to a schedule of charges that is made available to the public;

(C) in the case of individuals with an income greater than 100 percent of the official poverty line and not exceeding 200 percent of such poverty line, the provider will not, for any calendar year, impose charges in an amount exceeding 5 percent of the annual gross income of the individual involved;

(D) in the case of individuals with an income greater than 200 percent of the official poverty line and not exceeding 300 percent of such poverty line, the provider will not, for any calendar year, impose charges in an amount exceeding 7 percent of the annual gross income of the individual involved; and

(E) in the case of individuals with an income greater than 300 percent of the official poverty line, the provider will not, for any calendar year, impose charges in an amount exceeding 10 percent of the annual gross income of the individual involved.

(2) ASSESSMENT OF CHARGE.—With respect to compliance with the assurance made under paragraph (1), a grantee under [this part] *section 2611* may, in the case of individuals subject to a charge for purposes of such paragraph—

(A) assess the amount of the charge in the discretion of the grantee, including imposing only a nominal charge for the provision of services, subject to the provisions of such paragraph regarding public schedules regarding limitation on the maximum amount of charges; and

(B) take into consideration the medical expenses of individuals in assessing the amount of the charge, subject to such provisions.

(3) APPLICABILITY OF LIMITATION ON AMOUNT OF CHARGE.—The Secretary may not make a grant under section 2611 unless the applicant of the grant agrees that the limitations established in subparagraphs (C), (D), and (E) of paragraph (1) regarding the imposition of charges for services applies to the annual aggregate of charges imposed for such services, without regard to whether they are characterized as enrollment fees, premiums, deductibles, cost sharing, copayments, coinsurance, or other charges.

(4) WAIVER.—

(A) IN GENERAL.—The State shall waive the requirements established in paragraphs (1) through (3) in the case of an entity that does not, in providing health care services, impose a charge or accept reimbursement from any third-party payor, including reimbursement under any insurance policy or under any Federal or State health benefits program.

(B) DETERMINATION.—A determination by the State of whether an entity referred to in subparagraph (A) meets the criteria for a waiver under such subparagraph shall be made without regard to whether the entity accepts voluntary donations regarding the provision of services to the public.

(d) REQUIREMENT OF MATCHING FUNDS REGARDING STATE ALLOTMENTS.—

(1) IN GENERAL.—In the case of any State to which the criterion described in paragraph (3) applies, the Secretary may not make a grant under [this part] *section 2611* unless the State agrees that, with respect to the costs to be incurred by the State in carrying out the program for which the grant was awarded, the State will, subject to subsection (b)(2), make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount equal to—

(A) for the first fiscal year of payments under the grant, not less than 16⅔ percent of such costs ($1 for each $5 of Federal funds provided in the grant);

(B) for any second fiscal year of such payments, not less than 20 percent of such costs ($1 for each $4 of Federal funds provided in the grant);

(C) for any third fiscal year of such payments, not less than 25 percent of such costs ($1 for each $3 of Federal funds provided in the grant);

(D) for any fourth fiscal year of such payments, not less than 33⅓ percent of such costs ($1 for each $2 of Federal funds provided in the grant); and

(E) for any subsequent fiscal year of such payments, not less than 33⅓ percent of such costs ($1 for each $2 of Federal funds provided in the grant).

(2) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—

(A) IN GENERAL.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, and any portion of any service subsidized by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(B) INCLUSION OF CERTAIN AMOUNTS.—

(i) In making a determination of the amount of non-Federal contributions made by a State for purposes of paragraph (1), the Secretary shall, subject to clause (ii), include any non-Federal contributions provided by the State for HIV-related services, without regard to whether the contributions are made for programs established pursuant to this title;

(ii) In making a determination for purposes of clause (i), the Secretary may not include any non-Federal contributions provided by the State as a condition of receiving Federal funds under any program under this title (except for the program established in [this part] *section 2611*) or under other provisions of law.

(3) APPLICABILITY OF REQUIREMENT.—

(A) NUMBER OF CASES.—A State referred to in paragraph (1) is any State for which the number of cases of [acquired immune deficiency syndrome] *AIDS* reported to and confirmed by the Director of the Centers for Disease Control and Prevention for the period described in subparagraph (B) constitutes in excess of 1 percent of the aggregate number of such cases reported to and confirmed by the Director for such period for the United States.

(B) PERIOD OF TIME.—The period referred to in subparagraph (A) is the 2-year period preceding the fiscal year for which the State involved is applying to receive a grant under subsection (a).

(C) PUERTO RICO.—For purposes of paragraph (1), the number of cases of [acquired immune deficiency syndrome] *AIDS* reported and confirmed for the Commonwealth of Puerto Rico for any fiscal year shall be deemed to be less than 1 percent.

(4) DIMINISHED STATE CONTRIBUTION.—With respect to a State that does not make available the entire amount of the non-Federal contribution referred to in paragraph (1), the State shall continue to be eligible to receive Federal funds under a grant under [this part] *section 2611*, except that the Secretary in providing Federal funds under the grant shall provide such funds (in accordance with the ratios prescribed in paragraph (1)) only with respect to the amount of funds contributed by such State.

* * * * * * *

SEC. 2618. DISTRIBUTION OF FUNDS.

(a) AMOUNT OF GRANT TO STATE.—

(1) MINIMUM ALLOTMENT.—Subject to the extent of amounts made available under [section 2677] *section 2623*, the amount of a grant to be made under [this part] *section 2611* for—

(A) [each of the several States and the District of Columbia] *each of the 50 States, the District of Columbia, Guam, and the Virgin Islands (referred to in this paragraph as a "covered State")* for a fiscal year shall be the greater of—

(i)(I) with respect to a [State or District] *covered State* that has less than 90 living cases of [acquired immune deficiency syndrome] *AIDS*, as determined under paragraph (2)(D), $200,000; or

(II) with respect to a [State or District] *covered State* that has 90 or more living cases of [acquired immune deficiency syndrome] *AIDS*, as determined under paragraph (2)(D), $500,000; *and*

* * * * * * *

(B) [each territory of the United States, as defined in paragraph (3),] *each territory other than Guam and the Virgin Islands* shall be the greater of $50,000 or an amount determined under paragraph (2).

(2) DETERMINATION.—

(A) FORMULA.—[The amount referred to in paragraph (1)(A)(ii) for a State and paragraph (1)(B) for a territory of the United States shall be the product of—

[(i) an amount equal to the amount appropriated under section 2677 for the fiscal year involved for grants under part B, subject to subparagraphs (H) and (I); and] *For purposes of paragraph (1), the amount referred to in this paragraph for a State (including a territory) for a fiscal year is, subject to subparagraphs (E) and (F)—*

(i) an amount equal to the amount made available under section 2623 for the fiscal year involved for grants pursuant to paragraph (1), subject to subparagraph (G); and

(ii) the percentage constituted by the sum of—

(I) the product of [.80] *.75* and the ratio of the State distribution factor for the State or territory (as determined under subsection (B)) to the sum of the respective State distribution factors for all States or territories; [and]

(II) the product of .20 and the ratio of the non-EMA distribution factor for the State or territory (as determined under subparagraph (C)) to the sum of the respective *non-EMA* distribution factors for all States or territories[.]*; and*

(III) if the State does not for such fiscal year contain any area that is an eligible area under subpart I of part A or any area that is a transitional area under section 2609 (referred to in this subclause as a "no-EMA State"), the product of 0.05 and the ratio of the number of cases that applies for the State under subparagraph (D) to the sum of the respective numbers of cases that so apply for all no-EMA States.

(B) STATE DISTRIBUTION FACTOR.—For purposes of subparagraph (A)(ii)(I), the term "State distribution factor" means an amount equal to the [estimated number of living cases of acquired immune deficiency syndrome in the eligible area involved] *number of living cases of HIV/AIDS in the State involved*, as determined under subparagraph (D).

(C) NON-EMA DISTRIBUTION FACTOR.—For purposes of subparagraph (A)(ii)(II), the term "non-ema distribution factor" means an amount equal to the sum of—

(i) the [estimated number of living cases of acquired immune deficiency syndrome] *number of living cases of HIV/AIDS* in the State [or territory] involved, as determined under subparagraph (D); less

[(ii) the estimated number of living cases of acquired immune deficiency syndrome in such State or territory that are within an eligible area (as determined under part A).]

(ii) a number equal to the sum of—

(I) the total number of living cases of HIV/AIDS that are within areas in such State that are eligi-

ble areas under subpart I of part A for the fiscal year involved, which individual number for an area is the number that applies under section 2601 for the area for such fiscal year; and

(II) the total number of such cases that are within areas in such State that are transitional areas under section 2609 for such fiscal year, which individual number for an area is the number that applies under such section for the fiscal year.

[(D) ESTIMATE OF LIVING CASES.—The amount determined in this subparagraph is an amount equal to the product of—

[(i) the number of cases of acquired immune deficiency syndrome in the State or territory during each year in the most recent 120-month period for which data are available with respect to all States and territories, as indicated by the number of such cases reported to and confirmed by the Director of the Centers for Disease Control and Prevention for each year during such period, except that (subject to subparagraph (E)), for grants made pursuant to this paragraph or section 2620 for fiscal year 2005 and subsequent fiscal years, the cases counted for each 12-month period beginning on or after July 1, 2004, shall be cases of HIV disease (as reported to and confirmed by such Director) rather than cases of acquired immune deficiency syndrome; and

[(ii) with respect to each of the first through the tenth year during such period, the amount referred to in section 2603(a)(3)(C)(ii).

[(E) DETERMINATION OF SECRETARY REGARDING DATA ON HIV CASES.—If under section 2603(a)(3)(D)(i) the Secretary determines that data on cases of HIV disease are not sufficiently accurate and reliable, then notwithstanding subparagraph (D) of this paragraph, for any fiscal year prior to fiscal year 2007 the references in such subparagraph to cases of HIV disease do not have any legal effect.

[(F) PUERTO RICO, VIRGIN ISLANDS, GUAM.—For purposes of subparagraph (D), the cost index for Puerto Rico, the Virgin Islands, and Guam shall be 1.0.

[(G) UNEXPENDED FUNDS.—The Secretary may, in determining the amount of a grant for a fiscal year under this subsection, adjust the grant amount to reflect the amount of unexpended and uncanceled grant funds remaining at the end of the fiscal year preceding the year for which the grant determination is to be made. The amount of any such unexpended funds shall be determined using the financial status report of the grantee.

[(H) LIMITATION.—

[(i) IN GENERAL.—The Secretary shall ensure that the amount of a grant awarded to a State or territory under section 2611 or subparagraph (I)(i) for a fiscal year is not less than—

[(I) with respect to fiscal year 2001, 99 percent;

[(II) with respect to fiscal year 2002, 98 percent;

[(III) with respect to fiscal year 2003, 97 percent;

[(IV) with respect to fiscal year 2004, 96 percent; and

[(V) with respect to fiscal year 2005, 95 percent, of the amount such State or territory received for fiscal year 2000 under section 2611 or subparagraph (I)(i), respectively (notwithstanding such subparagraph). In administering this subparagraph, the Secretary shall, with respect to States or territories that will under such section receive grants in amounts that exceed the amounts that such States received under such section or subparagraph for fiscal year 2000, proportionally reduce such amounts to ensure compliance with this subparagraph. In making such reductions, the Secretary shall ensure that no such State receives less than that State received for fiscal year 2000.

[(ii) RATABLE REDUCTION.—If the amount appropriated under section 2677 for a fiscal year and available for grants under section 2611 or subparagraph (I)(i) is less than the amount appropriated and available for fiscal year 2000 under section 2611 or subparagraph (I)(i), respectively, the limitation contained in clause (i) for the grants involved shall be reduced by a percentage equal to the percentage of the reduction in such amounts appropriated and available.]

(D) LIVING CASES OF HIV/AIDS.—

(i) REQUIREMENT OF NAMES-BASED REPORTING.—Except as provided in clause (ii), the number determined under this subparagraph for a State for a fiscal year for purposes of subparagraph (B) is the number of living names-based cases of HIV/AIDS in the State that, as of December 31 of the most recent calendar year for which such data is available, have been reported to and confirmed by the Director of the Centers for Disease Control and Prevention.

(ii) TRANSITION PERIOD; EXEMPTION REGARDING NON-AIDS CASES.—For each of the fiscal years 2007 through 2010, a State is, subject to clauses (iii) through (v), exempt from the requirement under clause (i) that living non-AIDS names-based cases of HIV be reported unless—

(I) a system was in operation as of December 31, 2005, that provides sufficiently accurate and reliable names-based reporting of such cases throughout the State, subject to clause (vii); or

(II) no later than the beginning of fiscal year 2008, 2009, or 2010, the Secretary, after consultation with the chief executive of the State, determines that a system has become operational in the State that provides sufficiently accurate and reliable names-based reporting of such cases throughout the State.

(iii) REQUIREMENTS FOR EXEMPTION FOR FISCAL YEAR 2007.—For fiscal year 2007, an exemption under

clause (ii) for a State applies only if, by October 1, 2006—

(I)(aa) the State had submitted to the Secretary a plan for making the transition to sufficiently accurate and reliable names-based reporting of living non-AIDS cases of HIV; or

(bb) all statutory changes necessary to provide for sufficiently accurate and reliable reporting of such cases had been made; and

(II) the State had agreed that, by April 1, 2008, the State will begin accurate and reliable names-based reporting of such cases, except that such agreement is not required to provide that, as of such date, the system for such reporting be fully sufficient with respect to accuracy and reliability throughout the area.

(iv) REQUIREMENT FOR EXEMPTION AS OF FISCAL YEAR 2008.—For each of the fiscal years 2008 through 2010, an exemption under clause (ii) for a State applies only if, as of April 1, 2008, the State is substantially in compliance with the agreement under clause (iii)(II).

(v) PROGRESS TOWARD NAMES-BASED REPORTING.—For fiscal year 2009 or 2010, the Secretary may terminate an exemption under clause (ii) for a State if the State submitted a plan under clause (iii)(I)(aa) and the Secretary determines that the State is not substantially following the plan.

(vi) COUNTING OF CASES IN AREAS WITH EXEMPTIONS.—

(I) IN GENERAL.—With respect to a State that is under a reporting system for living non-AIDS cases of HIV that is not names-based (referred to in this subparagraph as "code-based reporting"), the Secretary shall, for purposes of this subparagraph, modify the number of such cases reported for the State in order to adjust for duplicative reporting in and among systems that use code-based reporting.

(II) ADJUSTMENT RATE.—The adjustment rate under subclause (I) for a State shall be a reduction of 5 percent in the number of living non-AIDS cases of HIV reported for the State.

(vii) LIST OF STATES MEETING STANDARD REGARDING DECEMBER 31, 2005.—

(I) IN GENERAL.—If a State is specified in subclause (II), the State shall be considered to meet the standard described in clause (ii)(I). No other State may be considered to meet such standard.

(II) RELEVANT STATES.—For purposes of subclause (I), the States specified in this subclause are the following: Alaska, Alabama, Arkansas, Arizona, Colorado, Florida, Indiana, Iowa, Idaho, Kansas, Louisiana, Michigan, Minnesota, Missouri, Mississippi, North Carolina, North Dakota, Nebraska, New Jersey, New Mexico, New York, Ne-

vada, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, West Virginia, Wyoming, Guam, and the Virgin Islands.

(viii) RULES OF CONSTRUCTION REGARDING ACCEPTANCE OF REPORTS.—

(I) CASES OF AIDS.—With respect to a State that is subject to the requirement under clause (i) and is not in compliance with the requirement for names-based reporting of living non-AIDS cases of HIV, the Secretary shall, notwithstanding such noncompliance, accept reports of living cases of AIDS that are in accordance with such clause.

(II) APPLICABILITY OF EXEMPTION REQUIREMENTS.—The provisions of clauses (ii) through (vii) may not be construed as having any legal effect for fiscal year 2011 or any subsequent fiscal year, and accordingly, the status of a State for purposes of such clauses may not be considered after fiscal year 2010.

(ix) PROGRAM FOR DETECTING INACCURATE OR FRAUDULENT COUNTING.—The Secretary shall carry out a program to monitor the reporting of names-based cases for purposes of this subparagraph and to detect instances of inaccurate reporting, including fraudulent reporting.

(E) CODE-BASED STATES; LIMITATION ON INCREASE IN GRANT.—

(i) IN GENERAL.—For each of the fiscal years 2007 through 2010, if code-based reporting (within the meaning of subparagraph (D)(vi)) applies in a State as of the beginning of the fiscal year involved, then notwithstanding any other provision of this paragraph, the amount of the grant pursuant to paragraph (1) for the State may not for the fiscal year involved exceed by more than 5 percent the amount of the grant pursuant to this paragraph for the State for the preceding fiscal year, except that the limitation under this clause may not result in a grant pursuant to paragraph (1) for a fiscal year that is less than the minimum amount that applies to the State under such paragraph for such fiscal year.

(ii) USE OF AMOUNTS INVOLVED.—For each of the fiscal years 2007 through 2010, amounts available as a result of the limitation under clause (i) shall be made available by the Secretary as additional amounts for grants pursuant to section 2620, subject to subparagraph (H).

(F) SEVERITY OF NEED.—

(i) FISCAL YEARS BEGINNING WITH 2011.—If, by January 1, 2010, the Secretary notifies the appropriate committees of Congress that the Secretary has developed a severity of need index in accordance with clause (v), the provisions of subparagraphs (A) through (E) shall not apply for fiscal year 2011 or any fiscal year thereafter,

and the Secretary shall use the severity of need index (as defined in clause (iv)) for the determination of the formula allocations, subject to the Congressional Review Act.

(ii) SUBSEQUENT FISCAL YEARS.—If, on or before any January 1 that is subsequent to the date referred to in clause (i), the Secretary notifies the appropriate committees of Congress that the Secretary has developed a severity of need index, in accordance with clause (v), for each succeeding fiscal year, the provisions of subparagraphs (A) through (D) shall not apply for the subsequent fiscal year or any fiscal year thereafter, and the Secretary shall use the severity of need index (as defined in clause (iv)) for the determination of the formula allocations, subject to the Congressional Review Act.

(iii) FISCAL YEAR 2013.—The Secretary shall notify the appropriate committees of Congress that the Secretary has developed a severity of need index by January 1, 2012, in accordance with clause (v), and the provisions of subparagraphs (A) through (D) shall not apply for fiscal year 2013 or any fiscal year thereafter, and the Secretary shall use the severity of need index (as defined in clause (iv)) for the determination of the formula allocations, subject to the Congressional Review Act.

(iv) DEFINITION OF SEVERITY OF NEED INDEX.—In this subparagraph, the term "severity of need index" means the index of the relative needs of individuals within the State, as identified by a variety of different factors, and is a factor that is multiplied by the number of living HIV/AIDS cases in the State, providing different weights to those cases based on their needs.

(v) REQUIREMENTS FOR SECRETARIAL NOTIFICATION.—When the Secretary notifies the appropriate committees of Congress that the Secretary has developed a severity of need index, the Secretary shall provide the following:

(I) Methodology for and rationale behind developing the severity of need index, including information related to the field testing of the severity of need index.

(II) An independent contractor analysis of activities carried out under subclause (I).

(III) Expected changes in funding allocations, given the application of the severity of need index and the elimination of the provisions of subparagraphs (A) through (D).

(IV) Information regarding the process by which the Secretary received community input regarding the application and development of the severity of need index.

(V) Timeline and process for the implementation of the severity of need index to ensure that it is applied in the following fiscal year.

(vi) ANNUAL REPORTS.—Not later than 1 year after the date of enactment of the Ryan White HIV/AIDS Treatment Modernization Act of 2006, and annually thereafter until the Secretary notifies Congress that the Secretary has developed a severity of need index in accordance with this subparagraph, the Secretary shall prepare and submit to the appropriate committees of Congress a report—

(I) that updates progress toward having client level data;

(II) that updates the progress toward having a severity of need index, including information related to the methodology and process for obtaining community input; and

(III) that, as applicable, states whether the Secretary could develop a severity of need index before fiscal year 2010.

[(I)**]** *(G)* APPROPRIATIONS FOR TREATMENT DRUG PROGRAM.—

(i) FORMULA GRANTS.—With respect to the fiscal year involved, if under **[**section 2677**]** *section 2623* an appropriations Act provides an amount exclusively for carrying out section 2616, the portion of such amount allocated to a State shall be the product of—

(I) 100 percent of such amount, less the percentage reserved under clause (ii)(V); and

(II) the percentage constituted by the ratio of the State distribution factor for the State (as determined under subparagraph (B)) to the sum of the State distribution factors for all States**[**.**]***;*

which product shall then, as applicable, be increased under subparagraph (H).

(ii) SUPPLEMENTAL TREATMENT DRUG GRANTS.—

[(I) IN GENERAL.—From amounts made available under subclause (V), the Secretary shall make supplemental grants to States described in subclause (II) to enable such States to increase access to therapeutics described in section 2616(a), as provided by the State under section 2616(c)(2).

[(II) ELIGIBLE STATES.—For purposes of subclause (I), a State described in this subclause is a State that, in accordance with criteria established by the Secretary, demonstrates a severe need for a grant under such subclause. In developing such criteria, the Secretary shall consider eligibility standards, formulary composition, and the number of eligible individuals at or below 200 percent of the official poverty line to whom the State is unable to provide therapeutics described in section 2616(a).

[(III) STATE REQUIREMENTS.—The Secretary may not make a grant to a State under this clause unless the State agrees that—

[(aa) the State will make available (directly or through donations from public or private

entities) non-Federal contributions toward the activities to be carried out under the grant in an amount equal to $1 for each $4 of Federal funds provided in the grant; and

[(bb) the State will not impose eligibility requirements for services or scope of benefits limitations under section 2616(a) that are more restrictive than such requirements in effect as of January 1, 2000.]

(I) IN GENERAL.—From amounts made available under subclause (V), the Secretary shall award supplemental grants to States described in subclause (II) to enable such States to purchase and distribute to eligible individuals under section 2616(b) pharmaceutical therapeutics described under subsections (c)(2) and (e) of such section.

(II) ELIGIBLE STATES.—For purposes of subclause (I), a State shall be an eligible State if the State did not have unobligated funds subject to reallocation under section 2618(d) in the previous fiscal year and, in accordance with criteria established by the Secretary, demonstrates a severe need for a grant under this clause. For purposes of determining severe need, the Secretary shall consider eligibility standards, formulary composition, the number of eligible individuals to whom a State is unable to provide therapeutics described in section 2616(a), and an unanticipated increase of eligible individuals with HIV/AIDS.

(III) STATE REQUIREMENTS.—The Secretary may not make a grant to a State under this clause unless the State agrees that the State will make available (directly or through donations of public or private entities) non-Federal contributions toward the activities to be carried out under the grant in an amount equal to $1 for each $4 of Federal funds provided in the grant, except that the Secretary may waive this subclause if the State has otherwise fully complied with section 2617(d) with respect to the grant year involved. The provisions of this subclause shall apply to States that are not required to comply with such section 2617(d).

(IV) USE AND COORDINATION.—Amounts made available under a grant under this clause shall only be used by the State to provide HIV/AIDS-related medications. The State shall coordinate the use of such amounts with the amounts otherwise provided under section 2616(a) in order to maximize drug coverage.

(V) FUNDING.—For the purpose of making grants under this clause, the Secretary shall each fiscal year reserve [3 percent] *5 percent* of the amount referred to in clause (i) with respect to section 2616, subject to subclause (VI).

[(VI) LIMITATION.—In reserving amounts under subclause (V) and making grants under this clause for a fiscal year, the Secretary shall ensure for each State that the total of the grant under section 2611 for the State for the fiscal year and the grant under clause (i) for the State for the fiscal year is not less than such total for the State for the preceding fiscal year.]

(iii) CODE-BASED STATES; LIMITATION ON INCREASE IN FORMULA GRANT.—The limitation under subparagraph (E)(i) applies to grants pursuant to clause (i) of this subparagraph to the same extent and in the same manner as such limitation applies to grants pursuant to paragraph (1), except that the reference to minimum grants does not apply for purposes of this clause. Amounts available as a result of the limitation under the preceding sentence shall be made available by the Secretary as additional amounts for grants under clause (ii) of this subparagraph.

(H) INCREASE IN FORMULA GRANTS.—

(i) IN GENERAL.—For each of the fiscal years 2007 through 2009, the Secretary shall ensure, subject to clauses (ii) through (iv), that the total for a State of the grant pursuant to paragraph (1) and the grant pursuant to subparagraph (G) is not less than 95 percent of such total for the State for the preceding fiscal year, except that any increase under this clause—

(I) may not result in a grant pursuant to paragraph (1) that is more than 95 percent of the amount of such grant for the preceding fiscal year; and

(II) may not result in a grant pursuant to subparagraph (G) that is more than 95 percent of the amount of such grant for such preceding fiscal year.

(ii) FISCAL YEAR 2007.—For purposes of clause (i) as applied for fiscal year 2007, the references in such clause to subparagraph (G) are deemed to be references to subparagraph (I) as such subparagraph was in effect for fiscal year 2006.

(iii) SOURCE OF FUNDS FOR INCREASE.—

(I) IN GENERAL.—From the amount reserved under section 2623(b)(2) for a fiscal year, and from amounts available for such section pursuant to subsection (d) of this section, the Secretary shall make available such amounts as may be necessary to comply with clause (i).

(II) PRO RATA REDUCTION.—If the amounts referred to in subclause (I) for a fiscal year are insufficient to fully comply with clause (i) for the year, the Secretary, in order to provide the additional funds necessary for such compliance, shall reduce on a pro rata basis the amount of each grant pursuant to paragraph (1) for the fiscal year, other than grants for States for which increases under

clause (i) apply and other than States described in paragraph (1)(A)(i)(I). A reduction under the preceding sentence may not be made in an amount that would result in the State involved becoming eligible for such an increase.

(iv) APPLICABILITY.—This paragraph may not be construed as having any applicability after fiscal year 2009.

[(3) DEFINITIONS.—As used in this subsection—

[(A) the term "State" means each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam; and

[(B) the term "territory of the United States" means, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau, and only for purposes of paragraph (1) the Commonwealth of Puerto Rico.]

(b) ALLOCATION OF ASSISTANCE BY STATES.—

[(2)] *(1)* ALLOWANCES.—Prior to allocating assistance under this subsection, a State shall consider the unmet needs of those areas that have not received financial assistance under part A.

[(3)] *(2)* PLANNING AND EVALUATIONS.—Subject to [paragraph (5)] *paragraph (4)* and except as provided in [paragraph (6)] *paragraph (5)*, a State may not use more than 10 percent of amounts received under a grant awarded under [this part] *section 2611* for planning and evaluation activities.

[(4)] *(3)* ADMINISTRATION.—

[(A) IN GENERAL.—Subject to paragraph (5) and except as provided in paragraph (6), a State may not use more than 10 percent of amounts received under a grant awarded under this part for administration. In the case of entities and subcontractors to which the State allocates amounts received by the State under the grant (including consortia under section 2613), the State shall ensure that, of the aggregate amount so allocated, the total of the expenditures by such entities for administrative expenses does not exceed 10 percent (without regard to whether particular entities expend more than 10 percent for such expenses).]

(A) IN GENERAL.—Subject to paragraph (4,) and except as provided in paragraph (5), a State may not use more than 10 percent of amounts received under a grant awarded under section 2611 for administration.

(B) ALLOCATIONS.—In the case of entities and subcontractors to which a State allocates amounts received by the State under a grant under section 2611, the State shall ensure that, of the aggregate amount so allocated, the total of the expenditures by such entities for administrative expenses does not exceed 10 percent (without regard to whether particular entities expend more than 10 percent for such expenses).

[(B)] *(C)* ADMINISTRATIVE ACTIVITIES.—For the purposes of subparagraph (A), amounts may be used for administrative activities that include routine grant administration

and monitoring activities*, including a clinical quality management program under subparagraph (E)*.

[(C)] *(D)* SUBCONTRACTOR ADMINISTRATIVE COSTS.—For the purposes of this paragraph, subcontractor administrative activities include—

(i) usual and recognized overhead, including established indirect rates for agencies;

(ii) management oversight of specific programs funded under this title; and

(iii) other types of program support such as quality assurance, quality control, and related activities.

(E) CLINICAL QUALITY MANAGEMENT.—

(i) REQUIREMENT.—Each State that receives a grant under section 2611 shall provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

(ii) USE OF FUNDS.—

(I) IN GENERAL.—From amounts received under a grant awarded under section 2611 for a fiscal year, a State may use for activities associated with the clinical quality management program required in clause (i) not to exceed the lesser of—

(aa) 5 percent of amounts received under the grant; or

(bb) $3,000,000.

(II) RELATION TO LIMITATION ON ADMINISTRATIVE EXPENSES.—The costs of a clinical quality management program under clause (i) may not be considered administrative expenses for purposes of the limitation established in subparagraph (A).

[(5)] *(4)* LIMITATION ON USE OF FUNDS.—Except as provided in [paragraph (6)] *paragraph (5)*, a State may not use more than a total of 15 percent of amounts received under a grant awarded under [this part] *section 2611* for the purposes described in [paragraphs (3) and (4)] *paragraphs (2) and (3)*.

[(6)] *(5)* EXCEPTION.—With respect to a State that receives the minimum allotment under subsection (a)(1) for a fiscal year, such State, from the amounts received under a grant awarded under [this part] *section 2611* for such fiscal year for the activities described in [paragraphs (3) and (4), may, notwithstanding paragraphs (3), (4), and (5),] *paragraphs (2) and (3), may, notwithstanding paragraphs (2) through (4),* use not more than that amount required to support one full-time-equivalent employee.

[(7)] *(6)* CONSTRUCTION.—A State may not use amounts received under a grant awarded under [this part] *section 2611* to purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building

or other facility, or to make cash payments to intended recipients of services.

(c) EXPEDITED DISTRIBUTION.—

(1) IN GENERAL.—Not less than 75 percent of the amounts received under a grant awarded to a State under [this part] *section 2611* shall be obligated to specific programs and projects and made available for expenditure not later than—

(A) * * *

* * * * * * *

[(d) REALLOCATION.—Any amounts appropriated in any fiscal year and made available to a State under this part that have not been obligated as described in subsection (d) shall be repaid to the Secretary and reallotted to other States in proportion to the original grants made to such States.]

(d) REALLOCATION.—Any portion of a grant made to a State under section 2611 for a fiscal year that has not been obligated as described in subsection (c) ceases to be available to the State and shall be made available by the Secretary for grants under section 2620, in addition to amounts made available for such grants under section 2623(b)(2).

* * * * * * *

SEC. 2620. SUPPLEMENTAL GRANTS.

(a) IN GENERAL.—For the purpose of providing services described in section 2612(a), the Secretary shall make grants to States—

(1) whose applications under section 2617 have demonstrated the need in the State, on an objective and quantified basis, for supplemental financial assistance to provide such services; and

(2) that did not, for the most recent grant year pursuant to section 2618(a)(1) or 2618(a)(2)(G)(i) for which data is available, have more than 2 percent of grant funds under such sections canceled or covered by any waivers under section 2622(c).

(b) DEMONSTRATED NEED.—The factors considered by the Secretary in determining whether an eligible area has a demonstrated need for purposes of subsection (a)(1) may include any or all of the following:

(1) The unmet need for such services, as determined under section 2617(b).

(2) An increasing need for HIV/AIDS-related services, including relative rates of increase in the number of cases of HIV/AIDS.

(3) The relative rates of increase in the number of cases of HIV/AIDS within new or emerging subpopulations.

(4) The current prevalence of HIV/AIDS.

(5) Relevant factors related to the cost and complexity of delivering health care to individuals with HIV/AIDS in the eligible area.

(6) The impact of co-morbid factors, including co-occurring conditions, determined relevant by the Secretary.

(7) The prevalence of homelessness.

(8) The prevalence of individuals described under section 2602(b)(2)(M).

(9) The relevant factors that limit access to health care, including geographic variation, adequacy of health insurance coverage, and language barriers.

(10) The impact of a decline in the amount received pursuant to section 2618 on services available to all individuals with HIV/AIDS identified and eligible under this title.

(c) PRIORITY IN MAKING GRANTS.—The Secretary shall provide funds under this section to a State to address the decline in services related to the decline in the amounts received pursuant to section 2618 consistent with the grant award to the State for fiscal year 2006, to the extent that the factor under subsection (b)(10) (relating to a decline in funding) applies to the State.

(d) CORE MEDICAL SERVICES.—The provisions of section 2612(b) apply with respect to a grant under this section to the same extent and in the same manner as such provisions apply with respect to a grant made pursuant to section 2618(a)(1).

(e) APPLICABILITY OF GRANT AUTHORITY.—The authority to make grants under this section applies beginning with the first fiscal year for which amounts are made available for such grants under section 2623(b)(1).

SEC. [2620] *2621.* [SUPPLEMENTAL GRANTS] *EMERGING COMMUNITIES.*

(a) * * *

(b) ELIGIBILITY.—To be eligible to receive a supplemental grant under subsection (a), a State shall—

(1) * * *

(2) demonstrate the existence in the State of an emerging community as defined in subsection (d)(1); [and]

(3) agree that the grant will be used to provide funds directly to emerging communities in the State, separately from other funds under this title that are provided by the State to such communities; and

[(3)] *(4)* submit the information described in subsection (c).

* * * * * * *

[(d) DEFINITION OF EMERGING COMMUNITY.—In this section, the term "emerging community" means a metropolitan area—

[(1) that is not eligible for a grant under part A; and

[(2) for which there has been reported to the Director of the Centers for Disease Control and Prevention a cumulative total of between 500 and 1,999 cases of acquired immune deficiency syndrome for the most recent period of 5 calendar years for which such data are available (except that, for fiscal year 2005 and subsequent fiscal years, cases of HIV disease shall be counted rather than cases of acquired immune deficiency syndrome if cases of HIV disease are being counted for purposes of section 2618(a)(2)(D)(i)).

[(e) FUNDING.—

[(1) IN GENERAL.—Subject to paragraph (2), with respect to each fiscal year beginning with fiscal year 2001, the Secretary, to carry out this section, shall utilize—

[(A) the greater of—

[(i) 25 percent of the amount appropriated under section 2677 to carry out part B, excluding the amount appropriated under section 2618(a)(2)(I), for such fiscal year that is in excess of the amount appropriated to carry out such part in the fiscal year preceding the fiscal year involved; or

[(ii) $5,000,000,

to provide funds to States for use in emerging communities with at least 1,000, but less than 2,000, cases of AIDS as reported to and confirmed by the Director of the Centers for Disease Control and Prevention for the five year period preceding the year for which the grant is being awarded; and

[(B) the greater of—

[(i) 25 percent of the amount appropriated under section 2677 to carry out part B, excluding the amount appropriated under section 2618(a)(2)(I), for such fiscal year that is in excess of the amount appropriated to carry out such part in the fiscal year preceding the fiscal year involved; or

[(ii) $5,000,000,

to provide funds to States for use in emerging communities with at least 500, but less than 1,000, cases of AIDS reported to and confirmed by the Director of the Centers for Disease Control and Prevention for the five year period preceding the year for which the grant is being awarded.

[(2) TRIGGER OF FUNDING.—This section shall be effective only for fiscal years beginning in the first fiscal year in which the amount appropriated under section 2677 to carry out part B, excluding the amount appropriated under section 2618(a)(2)(I), exceeds by at least $20,000,000 the amount appropriated under section 2677 to carry out part B in fiscal year 2000, excluding the amount appropriated under section 2618(a)(2)(I).

[(3) MINIMUM AMOUNT IN FUTURE YEARS.—Beginning with the first fiscal year in which amounts provided for emerging communities under paragraph (1)(A) equals $5,000,000 and under paragraph (1)(B) equals $5,000,000, the Secretary shall ensure that amounts made available under this section for the types of emerging communities described in each such paragraph in subsequent fiscal years is at least $5,000,000.

[(4) DISTRIBUTION.—Grants under this section for emerging communities shall be formula grants. There shall be two categories of such formula grants, as follows:

[(A) One category of such grants shall be for emerging communities for which the cumulative total of cases for purposes of subsection (d)(2) is 999 or fewer cases. The grant made to such an emerging community for a fiscal year shall be the product of—

[(i) an amount equal to 50 percent of the amount available pursuant to this subsection for the fiscal year involved; and

[(ii) a percentage equal to the ratio constituted by the number of cases for such emerging community for the fiscal year over the aggregate number of such cases for such year for all emerging communities to which this subparagraph applies.

[(B) The other category of formula grants shall be for emerging communities for which the cumulative total of cases for purposes of subsection (d)(2) is 1,000 or more

cases. The grant made to such an emerging community for a fiscal year shall be the product of—

[(i) an amount equal to 50 percent of the amount available pursuant to this subsection for the fiscal year involved; and

[(ii) a percentage equal to the ratio constituted by the number of cases for such community for the fiscal year over the aggregate number of such cases for the fiscal year for all emerging communities to which this subparagraph applies.]

(d) DEFINITIONS OF EMERGING COMMUNITY.—For purposes of this section, the term "emerging community" means a metropolitan area (as defined in section 2607) for which there has been reported to and confirmed by the Director of the Centers for Disease Control and Prevention a cumulative total of at least 500, but fewer than 1,000, cases of AIDS during the most recent period of 5 calendar years for which such data are available.

(e) CONTINUED STATUS AS EMERGING COMMUNITY.—Notwithstanding any other provision of this section, a metropolitan area that is an emerging community for a fiscal year continues to be an emerging community until the metropolitan area fails, for three consecutive fiscal years—

(1) to meet the requirements of subsection (d); and

(2) to have a cumulative total of 750 or more living cases of AIDS (reported to and confirmed by the Director of the Centers for Disease Control and Prevention) as of December 31 of the most recent calendar year for which such data is available.

(f) DISTRIBUTION.—The amount of a grant under subsection (a) for a State for a fiscal year shall be an amount equal to the product of—

(1) the amount available under section 2623(b)(1) for the fiscal year; and

(2) a percentage equal to the ratio constituted by the number of living cases of HIV/AIDS in emerging communities in the State to the sum of the respective numbers of such cases in such communities for all States.

SEC. 2622. TIMEFRAME FOR OBLIGATION AND EXPENDITURE OF GRANT FUNDS.

(a) OBLIGATION BY END OF GRANT YEAR.—Effective for fiscal year 2007 and subsequent fiscal years, funds from a grant award made to a State for a fiscal year pursuant to section 2618(a)(1) or 2618(a)(2)(G), or under section 2620 or 2621, are available for obligation by the State through the end of the one-year period beginning on the date in such fiscal year on which funds from the award first become available to the State (referred to in this section as the "grant year for the award"), except as provided in subsection (c)(1).

(b) SUPPLEMENTAL GRANTS; CANCELLATION OF UNOBLIGATED BALANCE OF GRANT AWARD.—Effective for fiscal year 2007 and subsequent fiscal years, if a grant award made to a State for a fiscal year pursuant to section 2618(a)(2)(G)(ii), or under section 2620 or 2621, has an unobligated balance as of the end of the grant year for the award—

(1) the Secretary shall cancel that unobligated balance of the award, and shall require the State to return any amounts from such balance that have been disbursed to the State; and

(2) the funds involved shall be made available by the Secretary as additional amounts for grants pursuant to section 2620 for the first fiscal year beginning after the fiscal year in which the Secretary obtains the information necessary for determining that the balance is required under paragraph (1) to be canceled, except that the availability of the funds for such grants is subject to section 2618(a)(2)(H) as applied for such year.

(c) FORMULA GRANTS; CANCELLATION OF UNOBLIGATED BALANCE OF GRANT AWARD; WAIVER PERMITTING CARRYOVER.—

(1) IN GENERAL.—Effective for fiscal year 2007 and subsequent fiscal years, if a grant award made to a State for a fiscal year pursuant to section 2618(a)(1) or 2618(a)(2)(G)(i) has an unobligated balance as of the end of the grant year for the award, the Secretary shall cancel that unobligated balance of the award, and shall require the State to return any amounts from such balance that have been disbursed to the State, unless—

(A) before the end of the grant year, the State submits to the Secretary a written application for a waiver of the cancellation, which application includes a description of the purposes for which the State intends to expend the funds involved; and

(B) the Secretary approves the waiver.

(2) EXPENDITURE BY END OF CARRYOVER YEAR.—With respect to a waiver under paragraph (1) that is approved for a balance that is unobligated as of the end of a grant year for an award:

(A) The unobligated funds are available for expenditure by the State involved for the one-year period beginning upon the expiration of the grant year (referred to in this section as the "carryover year").

(B) If the funds are not expended by the end of the carryover year, the Secretary shall cancel that unexpended balance of the award, and shall require the State to return any amounts from such balance that have been disbursed to the State.

(3) USE OF CANCELLED BALANCES.—In the case of any balance of a grant award that is cancelled under paragraph (1) or (2)(B), the grant funds involved shall be made available by the Secretary as additional amounts for grants under section 2620 for the first fiscal year beginning after the fiscal year in which the Secretary obtains the information necessary for determining that the balance is required under such paragraph to be canceled, except that the availability of the funds for such grants is subject to section 2618(a)(2)(H) as applied for such year.

(4) CORRESPONDING REDUCTION IN FUTURE GRANT.—

(A) IN GENERAL.—In the case of a State for which a balance from a grant award made pursuant to section 2618(a)(1) or 2618(a)(2)(G)(i) is unobligated as of the end of the grant year for the award—

(i) the Secretary shall reduce, by the same amount as such unobligated balance, the amount of the grant under such section for the first fiscal year beginning after the fiscal year in which the Secretary obtains the information necessary for determining that such bal-

ance was unobligated as of the end of the grant year (which requirement for a reduction applies without regard to whether a waiver under paragraph (1) has been approved with respect to such balance); and

(ii) the grant funds involved in such reduction shall be made available by the Secretary as additional funds for grants under section 2620 for such first fiscal year, subject to section 2618(a)(2)(H);

except that this subparagraph does not apply to the State if the amount of the unobligated balance was 2 percent or less.

(B) RELATION TO INCREASES IN GRANT.—A reduction under subparagraph (A) for a State for a fiscal year may not be taken into account in applying section 2618(a)(2)(H) with respect to the State for the subsequent fiscal year.

(d) TREATMENT OF DRUG REBATES.—For purposes of this section, funds that are drug rebates referred to in section 2616(g) may not be considered part of any grant award referred to in subsection (a).

SEC. 2623. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—For the purpose of carrying out this subpart, there are authorized to be appropriated $1,195,500,000 for fiscal year 2007, $1,239,500,000 for fiscal year 2008, $1,285,200,000 for fiscal year 2009, $1,332,600,000 for fiscal year 2010, and $1,381,700,000 for fiscal year 2011. Amounts appropriated under the preceding sentence for a fiscal year are available for obligation by the Secretary until the end of the second succeeding fiscal year.

(b) RESERVATION OF AMOUNTS.—

(1) EMERGING COMMUNITIES.—Of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall reserve $5,000,000 for grants under section 2621.

(2) SUPPLEMENTAL GRANTS.—

(A) IN GENERAL.—Of the amount appropriated under subsection (a) for a fiscal year in excess of the 2006 adjusted amount, the Secretary shall reserve 1/3 for grants under section 2620, except that the availability of the reserved funds for such grants is subject to section 2618(a)(2)(H) as applied for such year, and except that any amount appropriated exclusively for carrying out section 2616 (and, accordingly, distributed under section 2618(a)(2)(G)) is not subject to this subparagraph.

(B) 2006 ADJUSTED AMOUNT.—For purposes of subparagraph (A), the term "2006 adjusted amount" means the amount appropriated for fiscal year 2006 under section 2677(b) (as such section was in effect for such fiscal year), excluding any amount appropriated for such year exclusively for carrying out section 2616 (and, accordingly, distributed under section 2618(a)(2)(I), as so in effect).

Subpart II—Provisions Concerning Pregnancy and Perinatal Transmission of HIV

[SEC. 2625. CDC GUIDELINES FOR PREGNANT WOMEN.

[(a) REQUIREMENT.—Notwithstanding any other provision of law, a State shall, not later than 120 days after the date of enactment

of this subpart, certify to the Secretary that such State has in effect regulations or measures to adopt the guidelines issued by the Centers for Disease Control and Prevention concerning recommendations for human immunodeficiency virus counseling and voluntary testing for pregnant women.

[(b) NONCOMPLIANCE.—If a State does not provide the certification required under subsection (a) within the 120-day period described in such subsection, such State shall not be eligible to receive assistance for HIV counseling and testing under this section until such certification is provided.

[(c) ADDITIONAL FUNDS REGARDING WOMEN AND INFANTS.—

[(1) IN GENERAL.—If a State provides the certification required in subsection (a) and is receiving funds under part B for a fiscal year, the Secretary may (from the amounts available pursuant to paragraph (2)) make a grant to the State for the fiscal year for the following purposes:

[(A) Making available to pregnant women appropriate counseling on HIV disease.

[(B) Making available outreach efforts to pregnant women at high risk of HIV who are not currently receiving prenatal care.

[(C) Making available to such women voluntary HIV testing for such disease.

[(D) Offsetting other State costs associated with the implementation of this section and subsections (a) and (b) of section 2626.

[(E) Offsetting State costs associated with the implementation of mandatory newborn testing in accordance with this title or at an earlier date than is required by this title.

[(F) Making available to pregnant women with HIV disease, and to the infants of women with such disease, treatment services for such disease in accordance with applicable recommendations of the Secretary.

[(2) FUNDING.—

[(A) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there are authorized to be appropriated $30,000,000 for each of the fiscal years 2001 through 2005. Amounts made available under section 2677 for carrying out this part are not available for carrying out this section unless otherwise authorized.

[(B) ALLOCATIONS FOR CERTAIN STATES.—

[(i) IN GENERAL.—Of the amounts appropriated under subparagraph (A) for a fiscal year in excess of $10,000,000—

[(I) the Secretary shall reserve the applicable percentage under clause (iv) for making grants under paragraph (1) both to States described in clause (ii) and States described in clause (iii); and

[(II) the Secretary shall reserve the remaining amounts for other States, taking into consideration the factors described in subparagraph (C)(iii), except that this subclause does not apply to any State that for the fiscal year involved is receiving amounts pursuant to subclause (I).

[(ii) REQUIRED TESTING OF NEWBORNS.—For purposes of clause (i)(I), the States described in this clause are States that under law (including under regulations or the discretion of State officials) have—

[(I) a requirement that all newborn infants born in the State be tested for HIV disease and that the biological mother of each such infant, and the legal guardian of the infant (if other than the biological mother), be informed of the results of the testing; or

[(II) a requirement that newborn infants born in the State be tested for HIV disease in circumstances in which the attending obstetrician for the birth does not know the HIV status of the mother of the infant, and that the biological mother of each such infant, and the legal guardian of the infant (if other than the biological mother), be informed of the results of the testing.

[(iii) MOST SIGNIFICANT REDUCTION IN CASES OF PERINATAL TRANSMISSION.—For purposes of clause (i)(I), the States described in this clause are the following (exclusive of States described in clause (ii)), as applicable:

[(I) For fiscal years 2001 and 2002, the two States that, relative to other States, have the most significant reduction in the rate of new cases of the perinatal transmission of HIV (as indicated by the number of such cases reported to the Director of the Centers for Disease Control and Prevention for the most recent periods for which the data are available).

[(II) For fiscal years 2003 and 2004, the three States that have the most significant such reduction.

[(III) For fiscal year 2005, the four States that have the most significant such reduction.

[(iv) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable amount for a fiscal year is as follows:

[(I) For fiscal year 2001, 33 percent.

[(II) For fiscal year 2002, 50 percent.

[(III) For fiscal year 2003, 67 percent.

[(IV) For fiscal year 2004, 75 percent.

[(V) For fiscal year 2005, 75 percent.

[(C) CERTAIN PROVISIONS.—With respect to grants under paragraph (1) that are made with amounts reserved under subparagraph (B) of this paragraph:

[(i) Such a grant may not be made in an amount exceeding $4,000,000.

[(ii) If pursuant to clause (i) or pursuant to an insufficient number of qualifying applications for such grants (or both), the full amount reserved under subparagraph (B) for a fiscal year is not obligated, the requirement under such subparagraph to reserve amounts ceases to apply.

[(iii) In the case of a State that meets the conditions to receive amounts reserved under subparagraph (B)(i)(II), the Secretary shall in making grants consider the following factors:

[(I) The extent of the reduction in the rate of new cases of the perinatal transmission of HIV.

[(II) The extent of the reduction in the rate of new cases of perinatal cases of acquired immune deficiency syndrome.

[(III) The overall incidence of cases of infection with HIV among women of childbearing age.

[(IV) The overall incidence of cases of acquired immune deficiency syndrome among women of childbearing age.

[(V) The higher acceptance rate of HIV testing of pregnant women.

[(VI) The extent to which women and children with HIV disease are receiving HIV-related health services.

[(VII) The extent to which HIV-exposed children are receiving health services appropriate to such exposure.

[(3) PRIORITY.—In awarding grants under this subsection the Secretary shall give priority to States that have the greatest proportion of HIV seroprevalance among child bearing women using the most recent data available as determined by the Centers for Disease Control and Prevention.

[(4) MAINTENANCE OF EFFORT.—A condition for the receipt of a grant under paragraph (1) is that the State involved agree that the grant will be used to supplement and not supplant other funds available to the State to carry out the purposes of the grant.

SEC. 2625. EARLY DIAGNOSIS GRANT PROGRAM.

(a) IN GENERAL.—In the case of States whose laws or regulations are in accordance with subsection (b), the Secretary, acting through the Centers for Disease Control and Prevention, shall make grants to such States for the purposes described in subsection (c).

(b) DESCRIPTION OF COMPLIANT STATES.—For purposes of subsection (a), the laws or regulations of a State are in accordance with this subsection if, under such laws or regulations (including programs carried out pursuant to the discretion of State officials), both of the policies described in paragraph (1) are in effect, or both of the policies described in paragraph (2) are in effect, as follows:

(1)(A) Voluntary opt-out testing of pregnant women.

(B) Universal testing of newborns.

(2)(A) Voluntary opt-out testing of clients at sexually transmitted disease clinics.

(B) Voluntary opt-out testing of clients at substance abuse treatment centers.

The Secretary shall periodically ensure that the applicable policies are being carried out and recertify compliance.

(c) USE OF FUNDS.—A State may use funds provided under subsection (a) for HIV/AIDS testing (including rapid testing), prevention counseling, treatment of newborns exposed to HIV/AIDS, treatment of mothers infected with HIV/AIDS, and costs associated with

linking those diagnosed with HIV/AIDS to care and treatment for HIV/AIDS.

(d) APPLICATION.—A State that is eligible for the grant under subsection (a) shall submit an application to the Secretary, in such form, in such manner, and containing such information as the Secretary may require.

(e) LIMITATION ON AMOUNT OF GRANT.—A grant under subsection (a) to a State for a fiscal year may not be made in an amount exceeding $10,000,000.

(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to pre-empt State laws regarding HIV/AIDS counseling and testing.

(g) DEFINITIONS.—In this section:

(1) The term "voluntary opt-out testing" means HIV/AIDS testing—

(A) that is administered to an individual seeking other health care services; and

(B) in which—

(i) pre-test counseling is not required but the individual is informed that the individual will receive an HIV/AIDS test and the individual may opt out of such testing; and

(ii) for those individuals with a positive test result, post-test counseling (including referrals for care) is provided and confidentiality is protected.

(2) The term "universal testing of newborns" means HIV/AIDS testing that is administered within 48 hours of delivery to—

(A) all infants born in the State; or

(B) all infants born in the State whose mother's HIV/AIDS status is unknown at the time of delivery.

(h) AUTHORIZATION OF APPROPRIATIONS.—Of the funds appropriated annually to the Centers for Disease Control and Prevention for HIV/AIDS prevention activities, $30,000,000 shall be made available for each of the fiscal years 2007 through 2011 for grants under subsection (a), of which $20,000,000 shall be made available for grants to States with the policies described in subsection (b)(1), and $10,000,000 shall be made available for grants to States with the policies described in subsection (b)(2). Funds provided under this section are available until expended.

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Subpart III—Certain Partner Notification Programs

SEC. 2631. GRANTS FOR PARTNER NOTIFICATION PROGRAMS.

(a) * * *

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(b) DESCRIPTION OF COMPLIANT STATE PROGRAMS.—For purposes of subsection (a), the laws or regulations of a State are in accordance with this subsection if under such laws or regulations (including programs carried out pursuant to the discretion of State officials) the following policies are in effect:

(1) The State requires that the public health officer of the State carry out a program of partner notification to inform partners of individuals with [HIV disease] *HIV/AIDS* that the partners may have been exposed to the disease.

(2)(A) In the case of a health entity that provides for the performance on an individual of a test for [HIV disease] *HIV/AIDS*, or that treats the individual for the disease, the State requires, subject to subparagraph (B), that the entity confidentially report the positive test results to the State public health officer in a manner recommended and approved by the Director of the Centers for Disease Control and Prevention, together with such additional information as may be necessary for carrying out such program.

(B) The State may provide that the requirement of subparagraph (A) does not apply to the testing of an individual for [HIV disease] *HIV/AIDS* if the individual underwent the testing through a program designed to perform the test and provide the results to the individual without the individual disclosing his or her identity to the program. This subparagraph may not be construed as affecting the requirement of subparagraph (A) with respect to a health entity that treats an individual for [HIV disease] *HIV/AIDS*.

(3) The program under paragraph (1) is carried out in accordance with the following:

(A) Partners are provided with an appropriate opportunity to learn that the partners have been exposed to [HIV disease] *HIV/AIDS*, subject to subparagraph (B).

(B) The State does not inform partners of the identity of the infected individuals involved.

(C) Counseling and testing for [HIV disease] *HIV/AIDS* are made available to the partners and to infected individuals, and such counseling includes information on modes of transmission for the disease, including information on prenatal and perinatal transmission and preventing transmission.

* * * * * * *

(c) REPORTING SYSTEM FOR CASES OF [HIV DISEASE] *HIV/AIDS*; Preference in Making Grants.—In making grants under subsection (a), the Secretary shall give preference to States whose reporting systems for cases of [HIV disease] *HIV/AIDS* produce data on such cases that is sufficiently accurate and reliable for use for purposes of section 2618(a)(2)(D)(i).

(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, [there are authorized to be appropriated $30,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 through 2005.] *there is authorized to be appropriated $10,000,000 for each of the fiscal years 2007 through 2011.*

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PART C—Early Intervention Services

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Subpart I—Categorical Grants

[SEC. 2651. ESTABLISHMENT OF PROGRAM.

[(a) IN GENERAL.—For the purposes described in subsection (b), the Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to public and nonprofit private entities specified in section 2652(a).

[(b) PURPOSES OF GRANTS.—

[(1) IN GENERAL.—The Secretary may not make a grant under subsection (a) unless the applicant for the grant agrees to expend the grant for the purposes of providing, on an outpatient basis, each of the early intervention services specified in paragraph (2) with respect to HIV disease, and unless the applicant agrees to expend not less than 50 percent of the grant for such services that are specified in subparagraphs (B) through (E) of such paragraph for individuals with HIV disease.

[(2) SPECIFICATION OF EARLY INTERVENTION SERVICES.—The early intervention services referred to in paragraph (1) are—

[(A) counseling individuals with respect to HIV disease in accordance with section 2662;

[(B) testing individuals with respect to such disease, including tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease;

[(C) referrals described in paragraph (3);

[(D) other clinical and diagnostic services regarding HIV disease, and periodic medical evaluations of individuals with the disease;

[(E) providing the therapeutic measures described in subparagraph (B).

[(3) REFERRALS.—The services referred to in paragraph (2)(C) are referrals of individuals with HIV disease to appropriate providers of health and support services, including, as appropriate—

[(A) to entities receiving amounts under part A or B for the provision of such services;

[(B) to biomedical research facilities of institutions of higher education that offer experimental treatment for such disease, or to community-based organizations or other entities that provide such treatment; or

[(C) to grantees under section 2671, in the case of a pregnant woman.

[(4) REQUIREMENT OF AVAILABILITY OF ALL EARLY INTERVENTION SERVICES THROUGH EACH GRANTEE.—

[(A) IN GENERAL.—The Secretary may not make a grant under subsection (a) unless the applicant for the grant agrees that each of the early intervention services specified in paragraph (2) will be available through the grantee. With respect to compliance with such agreement, such a grantee may expend the grant to provide the early intervention services directly, and may expend the grant to

enter into agreements with public or nonprofit private entities, or private for-profit entities if such entities are the only available provider of quality HIV care in the area, under which the entities provide the services.

[(B) OTHER REQUIREMENTS.—Grantees described in—

[(i) paragraphs (1), (2), (5), and (6) of section 2652(a) shall use not less than 50 percent of the amount of such a grant to provide the services described in subparagraphs (A), (B), (D), and (E) of section 2651(b)(2) directly and on-site or at sites where other primary care services are rendered; and

[(ii) paragraphs (3) and (4) of section 2652(a) shall ensure the availability of early intervention services through a system of linkages to community-based primary care providers, and to establish mechanisms for the referrals described in section 2651(b)(2)(C), and for follow-up concerning such referrals.

[(5) OPTIONAL SERVICES.—A grantee under subsection (a)—

[(A) may expend the grant to provide outreach services to individuals who may have HIV disease or may be at risk of the disease, and who may be unaware of the availability and potential benefits of early treatment of the disease, and to provide outreach services to health care professionals who may be unaware of such availability and potential benefits; and

[(B) may, in the case of individuals who seek early intervention services from the grantee, expend the grant—

[(i) for case management to provide coordination in the provision of health care services to the individuals and to review the extent of utilization of the services by the individuals; and

[(ii) to provide assistance to the individuals regarding establishing the eligibility of the individuals for financial assistance and services under Federal, State, or local programs providing for health services, mental health services, social services, or other appropriate services.

[(c) PARTICIPATION IN CERTAIN CONSORTIUM.—The Secretary may not make a grant under subsection (a) unless the applicant for the grant agrees to make reasonable efforts to participate in a consortium established with a grant under section 2612(a)(1) regarding comprehensive services to individuals with HIV disease, if such a consortium exists in the geographic area with respect to which the applicant is applying to receive such a grant.]

SEC. 2651. ESTABLISHMENT OF A PROGRAM.

(a) IN GENERAL.—For the purposes described in subsection (b), the Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to public and nonprofit private entities specified in section 2652(a).

(b) REQUIREMENTS.—

(1) IN GENERAL.—The Secretary may not make a grant under subsection (a) unless the applicant for the grant agrees to expend the grant only for—

(A) core medical services described in subsection (c);

(B) support services described in subsection (d); and

(C) administrative expenses as described in section 2664(g)(3).

(2) EARLY INTERVENTION SERVICES.—An applicant for a grant under subsection (a) shall expend not less than 50 percent of the amount received under the grant for the services described in subparagraphs (B) through (E) of subsection (e)(1) for individuals with HIV/AIDS.

(c) REQUIRED FUNDING FOR CORE MEDICAL SERVICES.—

(1) IN GENERAL.—With respect to a grant under subsection (a) to an applicant for a fiscal year, the applicant shall, of the portion of the grant remaining after reserving amounts for purposes of paragraphs (3) and (5) of section 2664(g), use not less than 75 percent to provide core medical services that are needed in the area involved for individuals with HIV/AIDS who are identified and eligible under this title (including services regarding the co-occurring conditions of the individuals).

(2) WAIVER.—

(A) The Secretary shall waive the application of paragraph (1) with respect to an applicant for a grant if the Secretary determines that, within the service area of the applicant—

(i) there are no waiting lists for AIDS Drug Assistance Program services under section 2616; and

(ii) core medical services are available to all individuals with HIV/AIDS identified and eligible under this title.

(B) NOTIFICATION OF WAIVER STATUS.—When informing an applicant that a grant under subsection (a) is being made for a fiscal year, the Secretary shall inform the applicant whether a waiver under subparagraph (A) is in effect for the fiscal year.

(3) CORE MEDICAL SERVICES.—For purposes of this subsection, the term "core medical services", with respect to an individual with HIV/AIDS (including the co-occurring conditions of the individual) means the following services:

(A) Outpatient and ambulatory health services.

(B) AIDS Drug Assistance Program treatments under section 2616.

(C) AIDS pharmaceutical assistance.

(D) Oral health care.

(E) Early intervention services described in subsection (e).

(F) Health insurance premium and cost sharing assistance for low-income individuals in accordance with section 2615.

(G) Home health care.

(H) Medical nutrition therapy.

(I) Hospice services.

(J) Home and community-based health services as defined under section 2614(c).

(K) Mental health services.

(L) Substance abuse outpatient care.

(M) Medical case management, including treatment adherence services.

(d) SUPPORT SERVICES.—

(1) IN GENERAL.—For purposes of this section, the term "support services" means services, subject to the approval of the Secretary, that are needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services).

(2) DEFINITION OF MEDICAL OUTCOMES.—In this section, the term "medical outcomes" means those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

(e) SPECIFICATION OF EARLY INTERVENTION SERVICES.—

(1) IN GENERAL.—The early intervention services referred to in this section are—

(A) counseling individuals with respect to HIV/AIDS in accordance with section 2662;

(B) testing individuals with respect to HIV/AIDS, including tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from HIV/AIDS;

(C) referrals described in paragraph (2);

(D) other clinical and diagnostic services regarding HIV/AIDS, and periodic medical evaluations of individuals with HIV/AIDS; and

(E) providing the therapeutic measures described in subparagraph (B).

(2) REFERRALS.—The services referred to in paragraph (1)(C) are referrals of individuals with HIV/AIDS to appropriate providers of health and support services, including, as appropriate—

(A) to entities receiving amounts under part A or B for the provision of such services;

(B) to biomedical research facilities of institutions of higher education that offer experimental treatment for such disease, or to community-based organizations or other entities that provide such treatment; or

(C) to grantees under section 2671, in the case of a pregnant woman.

(3) REQUIREMENT OF AVAILABILITY OF ALL EARLY INTERVENTION SERVICES THROUGH EACH GRANTEE.—

(A) IN GENERAL.—The Secretary may not make a grant under subsection (a) unless the applicant for the grant agrees that each of the early intervention services specified in paragraph (2) will be available through the grantee. With respect to compliance with such agreement, such a grantee may expend the grant to provide the early intervention services directly, and may expend the grant to enter into agreements with public or nonprofit private entities, or private for-profit entities if such entities are the only available provider of quality HIV care in the area, under which the entities provide the services.

(B) OTHER REQUIREMENTS.—Grantees described in—

(i) subparagraphs (A), (D), (E), and (F) of section 2652(a)(1) shall use not less than 50 percent of the amount of such a grant to provide the services described in subparagraphs (A), (B), (D), and (E) of paragraph (1) directly and on-site or at sites where other primary care services are rendered; and

(ii) subparagraphs (B) and (C) of section 2652(a)(1) shall ensure the availability of early intervention services through a system of linkages to community-based primary care providers, and to establish mechanisms for the referrals described in paragraph (1)(C), and for follow-up concerning such referrals.

SEC. 2652. MINIMUM QUALIFICATIONS OF GRANTEES.

[(a) IN GENERAL.—The entities referred to in section 2651(a) are public entities and nonprofit private entities that are—

[(1) migrant health centers under section 329 or community health centers under section 330;

[(2) grantees under section 330(h) (regarding health services for the homeless);

[(3) grantees under section 1001 (regarding family planning) other than States;

[(4) comprehensive hemophilia diagnostic and treatment centers;

[(5) Federally-qualified health centers under section 1905(l)(2)(B) of the Social Security Act; or

[(6) nonprofit private entities that provide comprehensive primary care services to populations at risk of HIV disease.]

(a) ELIGIBLE ENTITIES.—

(1) IN GENERAL.—The entities referred to in section 2651(a) are public entities and nonprofit private entities that are—

(A) federally-qualified health centers under section 1905(l)(2)(B) of the Social Security Act;

(B) grantees under section 1001 (regarding family planning) other than States;

(C) comprehensive hemophilia diagnostic and treatment centers;

(D) rural health clinics;

(E) health facilities operated by or pursuant to a contract with the Indian Health Service;

(F) community-based organizations, clinics, hospitals and other health facilities that provide early intervention services to those persons infected with HIV/AIDS through intravenous drug use; or

(G) nonprofit private entities that provide comprehensive primary care services to populations at risk of HIV/AIDS, including faith-based and community-based organizations.

(2) UNDERSERVED POPULATIONS.—Entities described in paragraph (1) shall serve underserved populations which may include minority populations and Native American populations, ex-offenders, individuals with comorbidities including hepatitis B or C, mental illness, or substance abuse, low-income populations, inner city populations, and rural populations.

* * * * * * *

SEC. 2653. PREFERENCES IN MAKING GRANTS.

(a) IN GENERAL.—In making grants under section 2651, the Secretary shall give preference to any qualified applicant experiencing an increase in the burden of providing services regarding [HIV disease] *HIV/AIDS*, as indicated by the factors specified in subsection (b).

(b) SPECIFICATION OF FACTORS.—

(1) IN GENERAL.—In the case of the geographic area with respect to which the entity involved is applying for a grant under section 2651, the factors referred to in subsection (a), as determined for the period specified in paragraph (2), are—

(A) the number of cases of [acquired immune deficiency syndrome] *AIDS*;

* * * * * * *

(D) the number of other cases of sexually transmitted diseases, and the number of cases of tuberculosis and of drug abuse *and the number of cases of individuals co-infected with HIV/AIDS and hepatitis B or C*;

* * * * * * *

(d) CERTAIN AREAS.—Of the applicants who qualify for preference under this section—

(1) * * *

(2) the Secretary shall give [special consideration] *preference* to areas that are underserved with respect to such services.

SEC. 2654. MISCELLANEOUS PROVISIONS.

(a) * * *

* * * * * * *

(c) PLANNING AND DEVELOPMENT GRANTS.—

(1) IN GENERAL.—The Secretary may provide planning grants to public and nonprofit private entities for purposes of—

(A) enabling such entities to provide [HIV] early intervention services; and

(B) assisting the entities in expanding their capacity to provide [HIV] *HIV/AIDS*-related health services, including early intervention services, in low-income communities and affected subpopulations that are underserved with respect to such services (subject to the condition that a grant pursuant to this subparagraph may not be expended to purchase or improve land, or to purchase, construct, or permanently improve, other than minor remodeling, any building or other facility).

* * * * * * *

(3) PREFERENCE.—In awarding grants under paragraph (1), the Secretary shall give preference to entities that provide primary care services in rural [or underserved communities] *areas or to underserved populations*.

* * * * * * *

SEC. 2655. AUTHORIZATION OF APPROPRIATIONS.

For the purpose of making grants under section 2651, there are authorized to be appropriated [such sums as may be necessary for each of the fiscal years 2001 through 2005]*, $218,600,000 for fiscal year 2007, $226,700,000 for fiscal year 2008, $235,100,000 for fiscal*

year 2009, $243,800,000 for fiscal year 2010, and $252,800,000 for fiscal year 2011.

* * * * * * *

Subpart II—General Provisions

[SEC. 2661. CONFIDENTIALITY AND INFORMED CONSENT.

[(a) CONFIDENTIALITY.—The Secretary may not make a grant under this part unless, in the case of any entity applying for a grant under section 2651, the entity agrees to ensure that information regarding the receipt of early intervention services pursuant to the grant is maintained confidentially in a manner not inconsistent with applicable law.

[(b) INFORMED CONSENT.—

[(1) IN GENERAL.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that, in testing an individual for HIV disease, the applicant will test an individual only after obtaining from the individual a statement, made in writing and signed by the individual, declaring that the individual has undergone the counseling described in section 2662(a) and that the decision of the individual with respect to undergoing such testing is voluntarily made.

[(2) PROVISIONS REGARDING ANONYMOUS TESTING.—

[(A) If, pursuant to section 2664(b), an individual will undergo testing pursuant to this part through the use of a pseudonym, a grantee under such section shall be considered to be in compliance with the agreement made under paragraph (1) if the individual signs the statement described in such subsection using the pseudonym.

[(B) If, pursuant to section 2664(b), an individual will undergo testing pursuant to this part without providing any information relating to the identity of the individual, a grantee under such section shall be considered to be in compliance with the agreement made under paragraph (1) if the individual orally provides the declaration described in such paragraph.

[SEC. 2662. PROVISION OF CERTAIN COUNSELING SERVICES.

[(a) COUNSELING BEFORE TESTING.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that, before testing an individual for HIV disease, the applicant will provide to the individual appropriate counseling regarding the disease (based on the most recently available scientific data), including counseling on—

[(1) measures for the prevention of exposure to, and the transmission of, HIV;

[(2) the accuracy and reliability of the results of testing for HIV disease;

[(3) the significance of the results of such testing, including the potential for developing acquired immune deficiency syndrome;

[(4) encouraging the individual, as appropriate, to undergo such testing;

[(5) the benefits of such testing, including the medical benefits of diagnosing HIV disease in the early stages and the med-

ical benefits of receiving early intervention services during such stages;

[(6) provisions of law relating to the confidentiality of the process of receiving such services, including information regarding any disclosures that may be authorized under applicable law and information regarding the availability of anonymous counseling and testing pursuant to section 2664(b); and

[(7) provisions of applicable law relating to discrimination against individuals with HIV disease.

[(b) COUNSELING OF INDIVIDUALS WITH NEGATIVE TEST RESULTS.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that, if the results of testing conducted for HIV disease indicate that an individual does not have the disease, the applicant will review for the individual the information provided pursuant to subsection (a), including—

[(1) the information described in paragraphs (1) through (3) of such subsection; and

[(2) the appropriateness of further counseling, testing, and education of the individual regarding such disease.

[(c) COUNSELING OF INDIVIDUALS WITH POSITIVE TEST RESULTS.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that, if the results of testing for HIV disease indicate that the individual has the disease, the applicant will provide to the individual appropriate counseling regarding such disease, including—

[(1) reviewing the information described in paragraphs (1) through (3) of subsection (a);

[(2) reviewing the appropriateness of further counseling, testing, and education of the individual regarding such disease; and

[(3) providing counseling—

[(A) on the availability, through the applicant, of early intervention services;

[(B) on the availability in the geographic area of appropriate health care, mental health care, and social and support services, including providing referrals for such services, as appropriate;

[(C)(i) that explains the benefits of locating and counseling any individual by whom the infected individual may have been exposed to HIV and any individual whom the infected individual may have exposed to HIV; and

[(ii) that emphasizes it is the duty of infected individuals to disclose their infected status to their sexual partners and their partners in the sharing of hypodermic needles; that provides advice to infected individuals on the manner in which such disclosures can be made; and that emphasizes that it is the continuing duty of the individuals to avoid any behaviors that will expose others to HIV.

[(D) on the availability of the services of public health authorities with respect to locating and counseling any individual described in subparagraph (C).

[(d) ADDITIONAL REQUIREMENTS REGARDING APPROPRIATE COUNSELING.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that, in counseling individuals with respect to HIV disease, the applicant will ensure that the

counseling is provided under conditions appropriate to the needs of the individuals.

[(e) COUNSELING OF EMERGENCY RESPONSE EMPLOYEES.—The Secretary may not make a grant under this part to a State unless the State agrees that, in counseling individuals with respect to HIV disease, the State will ensure that, in the case of emergency response employees, the counseling is provided to such employees under conditions appropriate to the needs of the employees regarding the counseling.

[(f) RULE OF CONSTRUCTION REGARDING COUNSELING WITHOUT TESTING.—Agreements made pursuant to this section may not be construed to prohibit any grantee under this part from expending the grant for the purpose of providing counseling services described in this section to an individual who does not undergo testing for HIV disease as a result of the grantee or the individual determining that such testing of the individual is not appropriate.

SEC. 2661. CONFIDENTIALITY AND INFORMED CONSENT.

(a) CONFIDENTIALITY.—The Secretary may not make a grant under this part unless, in the case of any entity applying for a grant under section 2651, the entity agrees to ensure that information regarding the receipt of early intervention services pursuant to the grant is maintained confidentially in a manner not inconsistent with applicable law.

(b) INFORMED CONSENT.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that, in testing an individual for HIV/AIDS, the applicant will test an individual only after the individual confirms that the decision of the individual with respect to undergoing such testing is voluntarily made.

SEC. 2662. PROVISION OF CERTAIN COUNSELING SERVICES.

(a) COUNSELING OF INDIVIDUALS WITH NEGATIVE TEST RESULTS.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that, if the results of testing conducted for HIV/AIDS indicate that an individual does not have such condition, the applicant will provide the individual information, including—

(1) measures for prevention of, exposure to, and transmission of HIV/AIDS, hepatitis B, hepatitis C, and other sexually transmitted diseases;

(2) the accuracy and reliability of results of testing for HIV/AIDS, hepatitis B, and hepatitis C;

(3) the significance of the results of such testing, including the potential for developing AIDS, hepatitis B, or hepatitis C;

(4) the appropriateness of further counseling, testing, and education of the individual regarding HIV/AIDS and other sexually transmitted diseases;

(5) if diagnosed with chronic hepatitis B or hepatitis C co-infection, the potential of developing hepatitis-related liver disease and its impact on HIV/AIDS; and

(6) information regarding the availability of hepatitis B vaccine and information about hepatitis treatments.

(b) COUNSELING OF INDIVIDUALS WITH POSITIVE TEST RESULTS.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that, if the results of testing for HIV/

AIDS indicate that the individual has such condition, the applicant will provide to the individual appropriate counseling regarding the condition, including—

(1) information regarding—

(A) measures for prevention of, exposure to, and transmission of HIV/AIDS, hepatitis B, and hepatitis C;

(B) the accuracy and reliability of results of testing for HIV/AIDS, hepatitis B, and hepatitis C; and

(C) the significance of the results of such testing, including the potential for developing AIDS, hepatitis B, or hepatitis C;

(2) reviewing the appropriateness of further counseling, testing, and education of the individual regarding HIV/AIDS and other sexually transmitted diseases; and

(3) providing counseling—

(A) on the availability, through the applicant, of early intervention services;

(B) on the availability in the geographic area of appropriate health care, mental health care, and social and support services, including providing referrals for such services, as appropriate;

(C)(i) that explains the benefits of locating and counseling any individual by whom the infected individual may have been exposed to HIV/AIDS, hepatitis B, or hepatitis C and any individual whom the infected individual may have exposed to HIV/AIDS, hepatitis B, or hepatitis C; and

(ii) that emphasizes it is the duty of infected individuals to disclose their infected status to their sexual partners and their partners in the sharing of hypodermic needles; that provides advice to infected individuals on the manner in which such disclosures can be made; and that emphasizes that it is the continuing duty of the individuals to avoid any behaviors that will expose others to HIV/AIDS, hepatitis B, or hepatitis C; and

(D) on the availability of the services of public health authorities with respect to locating and counseling any individual described in subparagraph (C);

(4) if diagnosed with chronic hepatitis B or hepatitis C co-infection, the potential of developing hepatitis-related liver disease and its impact on HIV/AIDS; and

(5) information regarding the availability of hepatitis B vaccine.

(c) ADDITIONAL REQUIREMENTS REGARDING APPROPRIATE COUNSELING.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that, in counseling individuals with respect to HIV/AIDS, the applicant will ensure that the counseling is provided under conditions appropriate to the needs of the individuals.

(d) COUNSELING OF EMERGENCY RESPONSE EMPLOYEES.—The Secretary may not make a grant under this part to a State unless the State agrees that, in counseling individuals with respect to HIV/AIDS, the State will ensure that, in the case of emergency response employees, the counseling is provided to such employees under conditions appropriate to the needs of the employees regarding the counseling.

(e) RULE OF CONSTRUCTION REGARDING COUNSELING WITHOUT TESTING.—Agreements made pursuant to this section may not be construed to prohibit any grantee under this part from expending the grant for the purpose of providing counseling services described in this section to an individual who does not undergo testing for HIV/AIDS as a result of the grantee or the individual determining that such testing of the individual is not appropriate.

SEC. 2663. APPLICABILITY OF REQUIREMENTS REGARDING CONFIDENTIALITY, INFORMED CONSENT, AND COUNSELING.

The Secretary may not make a grant under this part unless the applicant for the grant agrees that, with respect to testing for [HIV disease] *HIV/AIDS*, any such testing carried out by the applicant [will, without regard to whether such testing is carried out with Federal funds, be carried] *with funds appropriated through this Act will be carried* out in accordance with conditions described in sections 2661 and 2662.

SEC. 2664. ADDITIONAL REQUIRED AGREEMENTS.

(a) REPORTS TO SECRETARY.—The Secretary may not make a grant under this part unless—

(1) the applicant submits to the Secretary—

(A) a specification of the expenditures made by the applicant for early intervention services for the fiscal year preceding the fiscal year for which the applicant is applying to receive the grant; [and]

(B) an estimate of the number of individuals to whom the applicant has provided such services for such fiscal year; [and]

(C) information regarding how the expected expenditures of the grant are related to the planning process for localities funded under part A (including the planning process described in section 2602) and for States funded under part B (including the planning process described in section 2617(b)); and

(D) a specification of the expected expenditures and how those expenditures will improve overall client outcomes, as described in the State plan under section 2617(b);

(2) the applicant agrees to submit to the Secretary a report providing—

(A) * * *

* * * * * * *

(E) the aggregate amounts expended for each such category[.]*;*

(3) the applicant agrees to provide additional documentation to the Secretary regarding the process used to obtain community input into the design and implementation of activities related to such grant; and

(4) the applicant agrees to submit, every 2 years, to the lead State agency under section 2617(b)(4) audits, consistent with Office of Management and Budget circular A133, regarding funds expended in accordance with this title and shall include necessary client level data to complete unmet need calculations and Statewide coordinated statements of need process.

* * * * * * *

(b) PROVISION OF OPPORTUNITIES FOR ANONYMOUS COUNSELING AND TESTING.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that, to the extent permitted under State law, regulation or rule, the applicant will offer substantial opportunities for an individual—

(1) to undergo counseling and testing regarding [HIV disease] *HIV/AIDS* without being required to provide any information relating to the identity of the individual; and

* * * * * * *

(f) RELATIONSHIP TO ITEMS AND SERVICES UNDER OTHER PROGRAMS.—

(1) IN GENERAL.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that, subject to paragraph (2), the grant will not be expended by the applicant, or by any entity receiving amounts from the applicant for the provision of early intervention services, to make payment for any such service to the extent that payment has been made, or can reasonably be expected to be made, with respect to such service—

(A) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program *(except for a program administered by or providing the services of the Indian Health Service)*; or

* * * * * * *

(g) ADMINISTRATION OF GRANT.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that—

(1) * * *

* * * * * * *

[(3) the applicant will not expend more than 10 percent including planning and evaluation of the grant for administrative expenses with respect to the grant;]

(3) the applicant will not expend more than 10 percent of the grant for administrative expenses with respect to the grant, including planning and evaluation, except that the costs of a clinical quality management program under paragraph (5) may not be considered administrative expenses for purposes of such limitation;

* * * * * * *

(5) the applicant will provide for the establishment of a *clinical* quality management program—

(A) to assess the extent to which medical services funded under this title that are provided to patients are consistent with the most recent Public Health Service guidelines for the treatment of [HIV disease] *HIV/AIDS* and related opportunistic infections, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines; and

* * * * * * *

SEC. 2667. USE OF FUNDS.

Counseling programs carried out under this part—

(1) shall not be designed to promote or encourage, directly, intravenous drug abuse or sexual activity, homosexual or heterosexual;

(2) shall be designed to reduce exposure to and transmission of [HIV disease] *HIV/AIDS* by providing accurate information; [and]

(3) shall provide information on the health risks of promiscuous sexual activity and intravenous drug abuse[.]*; and*

(4) shall provide information on the transmission and prevention of hepatitis A, B, and C, including education about the availability of hepatitis A and B vaccines and assisting patients in identifying vaccination sites.

* * * * * * *

[PART D—GENERAL PROVISIONS

[SEC. 2671. GRANTS FOR COORDINATED SERVICES AND ACCESS TO RESEARCH FOR WOMEN, INFANTS, CHILDREN, AND YOUTH.

[(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the National Institutes of Health, shall make grants to public and nonprofit private entities that provide primary care (directly or through contracts) for the following purposes:

[(1) Providing through such entities, in accordance with this section, opportunities for women, infants, children, and youth to be voluntary participants in research of potential clinical benefit to individuals with HIV disease.

[(2) In the case of women, infants, children, and youth with HIV disease, and the families of such individuals, providing to such individuals—

[(A) health care on an outpatient basis; and

[(B) additional services in accordance with subsection (d).

[(b) PROVISIONS REGARDING PARTICIPATION IN RESEARCH.—

[(1) IN GENERAL.—With respect to the projects of research with which an applicant under subsection (a) is concerned, the Secretary may make a grant under such subsection to the applicant only if the following conditions are met:

[(A) The applicant agrees to make reasonable efforts—

[(i) to identify which of the patients of the applicant are women, infants, children, and youth who would be appropriate participants in the projects;

[(ii) to carry out clause (i) through the use of criteria provided for such purpose by the entities that will be conducting the projects of research; and

[(iii) to offer women, infants, children, and youth the opportunity to participate in the projects (as appropriate), including the provision of services under subsection (d)(3).

[(B) The applicant agrees that, in the case of the research-related functions to be carried out by the applicant pursuant to subsection (a)(1), the applicant will comply with accepted standards that are applicable to such func-

tions (including accepted standards regarding informed consent and other protections for human subjects).

[(C) The applicant will demonstrate linkages to research and how access to such research is being offered to patients.

[(2) PROHIBITION.—Receipt of services by a patient shall not be conditioned upon the consent of the patient to participate in research.

[(c) PROVISIONS REGARDING CONDUCT OF RESEARCH.—

[(1) IN GENERAL.—With respect to eligibility for a grant under subsection (a):

[(A) A project of research for which subjects are sought pursuant to such subsection may be conducted by the applicant for the grant, or by an entity with which the applicant has made arrangements for purposes of the grant. The grant may not be expended for the conduct of any project of research, except for such research-related functions as are appropriate for providing opportunities under subsection (a)(1) (including the functions specified in subsection (b)(1)).

[(B) The grant may be made only if the Secretary makes the following determinations:

[(i) The applicant or other entity (as the case may be under subparagraph (A)) is appropriately qualified to conduct the project of research. An entity shall be considered to be so qualified if any research protocol of the entity has been recommended for funding under this Act pursuant to technical and scientific peer review through the National Institutes of Health.

[(ii) The project of research is being conducted in accordance with a research protocol to which the Secretary gives priority regarding the prevention or treatment of HIV disease in women, infants, children, or youth, subject to paragraph (2).

[(2) LIST OF RESEARCH PROTOCOLS.—

[(A) IN GENERAL.—From among the research protocols described in paragraph (1)(B)(ii), the Secretary shall establish a list of research protocols that are appropriate for purposes of subsection (a)(1). Such list shall be established only after consultation with public and private entities that conduct such research, and with providers of services under subsection (a) and recipients of such services.

[(B) DISCRETION OF SECRETARY.—The Secretary may authorize the use, for purposes of subsection (a)(1), of a research protocol that is not included on the list under subparagraph (A). The Secretary may waive the requirement specified in paragraph (1)(B)(ii) in such circumstances as the Secretary determines to be appropriate.

[(d) ADDITIONAL SERVICES FOR PATIENTS AND FAMILIES.—A grant under subsection (a) may be made only if the applicant for the grant agrees as follows:

[(1) The applicant will provide for the case management of the patient involved and the family of the patient.

[(2) The applicant will provide for the patient and the family of the patient—

[(A) referrals for inpatient hospital services, treatment for substance abuse, and mental health services; and

[(B) referrals for other social and support services, as appropriate.

[(3) The applicant will provide the patient and the family of the patient with such transportation, child care, and other incidental services as may be necessary to enable the patient and the family to participate in the program established by the applicant pursuant to such subsection.

[(4) The applicant will provide individuals with information and education on opportunities to participate in HIV/AIDS-related clinical research.

[(e) COORDINATION WITH OTHER ENTITIES.—A grant under subsection (a) may be made only if the applicant for the grant agrees as follows:

[(1) The applicant will coordinate activities under the grant with other providers of health care services under this Act, and under title V of the Social Security Act.

[(2) The applicant will participate in the statewide coordinated statement of need under part B (where it has been initiated by the public health agency responsible for administering grants under part B) and in revisions of such statement.

[(f) ADMINISTRATION.—

[(1) APPLICATION.—A grant under subsection (a) may be made only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

[(2) QUALITY MANAGEMENT PROGRAM.—A grantee under this section shall implement a quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

[(g) COORDINATION WITH NATIONAL INSTITUTES OF HEALTH.—The Secretary shall develop and implement a plan that provides for the coordination of the activities of the National Institutes of Health with the activities carried out under this section. In carrying out the preceding sentence, the Secretary shall ensure that projects of research conducted or supported by such Institutes are made aware of applicants and grantees under subsection (a), shall require that the projects, as appropriate, enter into arrangements for purposes of such subsection, and shall require that each project entering into such an arrangement inform the applicant or grantee under such subsection of the needs of the project for the participation of women, infants, children, and youth. The Secretary acting through the Director of NIH, shall examine the distribution and availability of ongoing and appropriate HIV/AIDS-related research projects to existing sites under this section for purposes of enhancing and expanding voluntary access to HIV-related research, especially within communities that are not reasonably served by such

projects. Not later than 12 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000, the Secretary shall prepare and submit to the appropriate committees of Congress a report that describes the findings made by the Director and the manner in which the conclusions based on those findings can be addressed.

[(h) ANNUAL REVIEW OF PROGRAMS; EVALUATIONS.—

[(1) REVIEW REGARDING ACCESS TO AND PARTICIPATION IN PROGRAMS.—With respect to a grant under subsection (a) for an entity for a fiscal year, the Secretary shall, not later than 180 days after the end of the fiscal year, provide for the conduct and completion of a review of the operation during the year of the program carried out under such subsection by the entity. The purpose of such review shall be the development of recommendations, as appropriate, for improvements in the following:

[(A) Procedures used by the entity to allocate opportunities and services under subsection (a) among patients of the entity who are women, infants, children, or youth.

[(B) Other procedures or policies of the entity regarding the participation of such individuals in such program.

[(2) EVALUATIONS.—The Secretary shall, directly or through contracts with public and private entities, provide for evaluations of programs carried out pursuant to subsection (a).

[(i) LIMITATION ON ADMINISTRATIVE EXPENSES.—

[(1) DETERMINATION BY SECRETARY.—Not later than 12 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000, the Secretary, in consultation with grantees under this part, shall conduct a review of the administrative, program support, and direct service-related activities that are carried out under this part to ensure that eligible individuals have access to quality, HIV-related health and support services and research opportunities under this part, and to support the provision of such services.

[(2) REQUIREMENTS.—

[(A) IN GENERAL.—Not later than 180 days after the expiration of the 12-month period referred to in paragraph (1) the Secretary, in consultation with grantees under this part, shall determine the relationship between the costs of the activities referred to in paragraph (1) and the access of eligible individuals to the services and research opportunities described in such paragraph.

[(B) LIMITATION.—After a final determination under subparagraph (A), the Secretary may not make a grant under this part unless the grantee complies with such requirements as may be included in such determination.

[(j) TRAINING AND TECHNICAL ASSISTANCE.—Of the amounts appropriated under subsection (j) for a fiscal year, the Secretary may use not more than five percent to provide, directly or through contracts with public and private entities (which may include grantees under subsection (a)), training and technical assistance to assist applicants and grantees under subsection (a) in complying with the requirements of this section.

[(k) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated

such sums as may be necessary for each of the fiscal years 1996 through 2000.

[SEC. 2672. PROVISIONS RELATING TO BLOOD BANKS.

[(a) INFORMATIONAL AND TRAINING PROGRAMS.—The Secretary shall—

[(1) develop and make available to technical and supervisory personnel employed at blood banks and facilities that produce blood products, materials and information concerning measures that may be implemented to protect the safety of the blood supply with respect to the activities of such personnel, including—

[(A) state-of-the-art diagnostic and testing procedures relating to pathogens in the blood supply; and

[(B) quality assurance procedures relating to the safety of the blood supply and of blood products; and

[(2) develop and implement a training program that is designed to increase the number of employees of the Department of Health and Human Services who are qualified to conduct inspections of blood banks and facilities that produce blood products.

[(b) UPDATES.—The Secretary shall periodically review and update the materials and information made available under informational or training programs conducted under subsection (a).

[(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $1,500,000 for fiscal year 1991, and such sums as may be necessary in each of the fiscal years 1992 through 1995.

[SEC. 2673. RESEARCH, EVALUATION, AND ASSESSMENT PROGRAM.

[(a) ESTABLISHMENT.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a program to enable independent research to be conducted by individuals and organizations with appropriate expertise in the fields of health, health policy, and economics (particularly health care economics) to develop—

[(1) a comparative assessment of the impact and cost-effectiveness of major models for organizing and delivering HIV-related health care, mental health care, early intervention, and support services, that shall include a report concerning patient outcomes, satisfaction, perceived quality of care, and total cumulative cost, and a review of the appropriateness of such models for the delivery of health and support services to infants, children, women, and families with HIV disease;

[(2) through a review of private sector financing mechanisms for the delivery of HIV-related health and support services, an assessment of strategies for maintaining private health benefits for individuals with HIV disease and an assessment of specific business practices or regulatory barriers that could serve to reduce access to private sector benefit programs;

[(3) an assessment of the manner in which different points-of-entry to the health care system affect the cost, quality, and outcome of the care and treatment of individuals and families with HIV disease; and

[(4) a summary report concerning the major and continuing unmet needs in health care, mental health care, early inter-

vention, and support services for individuals and families with HIV disease in urban and rural areas.

[(b) REPORT.—Not later than 2 years after the date of enactment of this title, and periodically thereafter, the Secretary shall prepare and submit, to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate, a progress report that contains the findings and assessments developed under subsection (a).

[(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of the fiscal years 1991 through 1995.

[SEC. 2674. EVALUATIONS AND REPORTS.

[(a) EVALUATIONS.—The Secretary shall, directly or through grants and contracts, evaluate programs carried out under this title.

[(b) REPORT TO CONGRESS.—The Secretary shall, not later than October 1, 1996, and annually thereafter, prepare and submit to the appropriate Committees of Congress a report—

[(1) evaluating the programs carried out under this title; and

[(2) making such recommendations for administrative and legislative initiatives with respect to this title as the Secretary determines to be appropriate.

[(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of the fiscal years 2001 through 2005.

[(d) ALLOCATION OF FUNDS.—The Secretary shall carry out this section with amounts available under section 241. Such amounts are in addition to any other amounts that are available to the Secretary for such purpose.

[SEC. 2675. COORDINATION.

[(a) REQUIREMENT.—The Secretary shall ensure that the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Centers for Medicare & Medicaid Services coordinate the planning, funding, and implementation of Federal HIV programs to enhance the continuity of care and prevention services for individuals with HIV disease or those at risk of such disease. The Secretary shall consult with other Federal agencies, including the Department of Veterans Affairs, as needed and utilize planning information submitted to such agencies by the States and entities eligible for support.

[(b) REPORT.—The Secretary shall biennially prepare and submit to the appropriate committees of the Congress a report concerning the coordination efforts at the Federal, State, and local levels described in this section, including a description of Federal barriers to HIV program integration and a strategy for eliminating such barriers and enhancing the continuity of care and prevention services for individuals with HIV disease or those at risk of such disease.

[(c) INTEGRATION BY STATE.—As a condition of receipt of funds under this title, a State shall assure the Secretary that health support services funded under this title will be integrated with each other, that programs will be coordinated with other available pro-

grams (including Medicaid) and that the continuity of care and prevention services of individuals with HIV disease is enhanced.

[(d) INTEGRATION BY LOCAL OR PRIVATE ENTITIES.—As a condition of receipt of funds under this title, a local government or private nonprofit entity shall assure the Secretary that services funded under this title will be integrated with each other, that programs will be coordinated with other available programs (including Medicaid) and that the continuity of care and prevention services of individuals with HIV is enhanced.

[(e) RECOMMENDATIONS REGARDING RELEASE OF PRISONERS.—After consultation with the Attorney General and the Director of the Bureau of Prisons, with States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary, consistent with the coordination required in subsection (a), shall develop a plan for the medical case management of and the provision of support services to individuals who were Federal or State prisoners and had HIV disease as of the date on which the individuals were released from the custody of the penal system. The Secretary shall submit the plan to the Congress not later than 2 years after the date of the enactment of the Ryan White CARE Act Amendments of 2000.

[SEC. 2675A. AUDITS.

[For fiscal year 2002 and subsequent fiscal years, the Secretary may reduce the amounts of grants under this title to a State or political subdivision of a State for a fiscal year if, with respect to such grants for the second preceding fiscal year, the State or subdivision fails to prepare audits in accordance with the procedures of section 7502 of title 31, United States Code. The Secretary shall annually select representative samples of such audits, prepare summaries of the selected audits, and submit the summaries to the Congress.

[SEC. 2675B. ADMINISTRATIVE SIMPLIFICATION REGARDING PARTS A AND B.

[(a) COORDINATED DISBURSEMENT.—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall develop a plan for coordinating the disbursement of appropriations for grants under part A with the disbursement of appropriations for grants under part B in order to assist grantees and other recipients of amounts from such grants in complying with the requirements of such parts. The Secretary shall submit the plan to the Congress not later than 18 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000. Not later than 2 years after the date on which the plan is so submitted, the Secretary shall complete the implementation of the plan, notwithstanding any provision of this title that is inconsistent with the plan.

[(b) BIENNIAL APPLICATIONS.—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall make a determination of whether the administration of parts A and B by the Secretary, and the efficiency of grantees under such parts in complying with the requirements of such parts, would be improved by requiring that applications for grants under such parts be submitted biennially rather than annually. The Secretary shall submit

such determination to the Congress not later than 2 years after the date of the enactment of the Ryan White CARE Act Amendments of 2000.

[(c) APPLICATION SIMPLIFICATION.—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall develop a plan for simplifying the process for applications under parts A and B. The Secretary shall submit the plan to the Congress not later than 18 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000. Not later than 2 years after the date on which the plan is so submitted, the Secretary shall complete the implementation of the plan, notwithstanding any provision of this title that is inconsistent with the plan.

[SEC. 2676. DEFINITIONS.

[For purposes of this title:

[(1) COUNSELING.—The term "counseling" means such counseling provided by an individual trained to provide such counseling.

[(2) DESIGNATED OFFICER OF EMERGENCY RESPONSE EMPLOYEES.—The term "designated officer of emergency response employees" means an individual designated under section 2686 by the public health officer of the State involved.

[(3) EMERGENCY.—The term "emergency" means an emergency involving injury or illness.

[(4) EMERGENCY RESPONSE EMPLOYEE.—The term "emergency response employees" means firefighters, law enforcement officers, paramedics, emergency medical technicians, funeral-service practitioners, and other individuals (including employees of legally organized and recognized volunteer organizations, without regard to whether such employees receive nominal compensation) who, in the course of professional duties, respond to emergencies in the geographic area involved.

[(5) EMPLOYER OF EMERGENCY RESPONSE EMPLOYEES.—The term "employer of emergency response employees" means an organization that, in the course of professional duties, responds to emergencies in the geographic area involved.

[(6) EXPOSED.—The term "exposed", with respect to HIV disease or any other infectious disease, means to be in circumstances in which there is a significant risk of becoming infected with the etiologic agent for the disease involved.

[(7) FAMILIES WITH HIV DISEASE.—The term "families with HIV disease" means families in which one or more members have HIV disease.

[(8) HIV.—The term "HIV" means infection with the etiologic agent for acquired immune deficiency syndrome.

[(9) HIV DISEASE.—The term "HIV disease" means infection with the etiologic agent for acquired immune deficiency syndrome, and includes any condition arising from such syndrome.

[(10) OFFICIAL POVERTY LINE.—The term "official poverty line" means the poverty line established by the Director of the Office of Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

[(11) PERSON.—The term "person" includes one or more individuals, governments (including the Federal Government and the governments of the States), governmental agencies, political subdivisions, labor unions, partnerships, associations, corporations, legal representatives, mutual companies, joint-stock companies, trusts, unincorporated organizations, receivers, trustees, and trustees in cases under title 11, United States Code.

[(12) STATE.—The term "State", except as otherwise specifically provided, means each of the 50 States, the District of Columbia, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Republic of the Marshall Islands.

[SEC. 2677. AUTHORIZATION OF APPROPRIATIONS.

[(a) PART A.—For the purpose of carrying out part A, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

[(b) PART B.—For the purpose of carrying out part B, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

[SEC. 2678. PROHIBITION ON PROMOTION OF CERTAIN ACTIVITIES.

[None of the funds authorized under this title shall be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual. Funds authorized under this title may be used to provide medical treatment and support services for individuals with HIV.

[PART E—EMERGENCY RESPONSE EMPLOYEES

[Subpart I—Guidelines and Model Curriculum

[SEC. 2680. GRANTS FOR IMPLEMENTATION.

[(a) IN GENERAL.—With respect to the recommendations contained in the guidelines and the model curriculum developed under section 253 of Public Law 100-607, the Secretary shall make grants to States and political subdivisions of States for the purpose of assisting grantees regarding the initial implementation of such portions of the recommendations as are applicable to emergency response employees.

[(b) REQUIREMENT OF APPLICATION.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

[(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $5,000,000 for each of the fiscal years 1991 through 1995.

[Subpart II—Notifications of Possible Exposure to Infectious Diseases

[SEC. 2681. INFECTIOUS DISEASES AND CIRCUMSTANCES RELEVANT TO NOTIFICATION REQUIREMENTS.

[(a) IN GENERAL.—Not later than 180 days after the date of the enactment of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, the Secretary shall complete the development of—

[(1) a list of potentially life-threatening infectious diseases to which emergency response employees may be exposed in responding to emergencies;

[(2) guidelines describing the circumstances in which such employees may be exposed to such diseases, taking into account the conditions under which emergency response is provided; and

[(3) guidelines describing the manner in which medical facilities should make determinations for purposes of section 2683(d).

[(b) SPECIFICATION OF AIRBORNE INFECTIOUS DISEASES.—The list developed by the Secretary under subsection (a)(1) shall include a specification of those infectious diseases on the list that are routinely transmitted through airborne or aerosolized means.

[(c) DISSEMINATION.—The Secretary shall—

[(1) transmit to State public health officers copies of the list and guidelines developed by the Secretary under subsection (a) with the request that the officers disseminate such copies as appropriate throughout the States; and

[(2) make such copies available to the public.

[SEC. 2682. ROUTINE NOTIFICATIONS WITH RESPECT TO AIRBORNE INFECTIOUS DISEASES IN VICTIMS ASSISTED.

[(a) ROUTINE NOTIFICATION OF DESIGNATED OFFICER.—

[(1) DETERMINATION BY TREATING FACILITY.—If a victim of an emergency is transported by emergency response employees to a medical facility and the medical facility makes a determination that the victim has an airborne infectious disease, the medical facility shall notify the designated officer of the emergency response employees who transported the victim to the medical facility of the determination.

[(2) DETERMINATION BY FACILITY ASCERTAINING CAUSE OF DEATH.—If a victim of an emergency is transported by emergency response employees to a medical facility and the victim dies at or before reaching the medical facility, the medical facility ascertaining the cause of death shall notify the designated officer of the emergency response employees who transported the victim to the initial medical facility of any determination by the medical facility that the victim had an airborne infectious disease.

[(b) REQUIREMENT OF PROMPT NOTIFICATION.—With respect to a determination described in paragraph (1) or (2), the notification required in each of such paragraphs shall be made as soon as is practicable, but not later than 48 hours after the determination is made.

[SEC. 2683. REQUEST FOR NOTIFICATIONS WITH RESPECT TO VICTIMS ASSISTED.

[(a) INITIATION OF PROCESS BY EMPLOYEE.—If an emergency response employee believes that the employee may have been exposed to an infectious disease by a victim of an emergency who was transported to a medical facility as a result of the emergency, and if the employee attended, treated, assisted, or transported the victim pursuant to the emergency, then the designated officer of the employee shall, upon the request of the employee, carry out the duties described in subsection (b) regarding a determination of whether the employee may have been exposed to an infectious disease by the victim.

[(b) INITIAL DETERMINATION BY DESIGNATED OFFICER.—The duties referred to in subsection (a) are that—

[(1) the designated officer involved collect the facts relating to the circumstances under which, for purposes of subsection (a), the employee involved may have been exposed to an infectious disease; and

[(2) the designated officer evaluate such facts and make a determination of whether, if the victim involved had any infectious disease included on the list issued under paragraph (1) of section 2681(a), the employee would have been exposed to the disease under such facts, as indicated by the guidelines issued under paragraph (2) of such section.

[(c) SUBMISSION OF REQUEST TO MEDICAL FACILITY.—

[(1) IN GENERAL.—If a designated officer makes a determination under subsection (b)(2) that an emergency response employee may have been exposed to an infectious disease, the designated officer shall submit to the medical facility to which the victim involved was transported a request for a response under subsection (d) regarding the victim of the emergency involved.

[(2) FORM OF REQUEST.—A request under paragraph (1) shall be in writing and be signed by the designated officer involved, and shall contain a statement of the facts collected pursuant to subsection (b)(1).

[(d) EVALUATION AND RESPONSE REGARDING REQUEST TO MEDICAL FACILITY.—

[(1) IN GENERAL.—If a medical facility receives a request under subsection (c), the medical facility shall evaluate the facts submitted in the request and make a determination of whether, on the basis of the medical information possessed by the facility regarding the victim involved, the emergency response employee was exposed to an infectious disease included on the list issued under paragraph (1) of section 2681(a), as indicated by the guidelines issued under paragraph (2) of such section.

[(2) NOTIFICATION OF EXPOSURE.—If a medical facility makes a determination under paragraph (1) that the emergency response employee involved has been exposed to an infectious disease, the medical facility shall, in writing, notify the designated officer who submitted the request under subsection (c) of the determination.

[(3) FINDING OF NO EXPOSURE.—If a medical facility makes a determination under paragraph (1) that the emergency response employee involved has not been exposed to an infectious

disease, the medical facility shall, in writing, inform the designated officer who submitted the request under subsection (c) of the determination.

[(4) INSUFFICIENT INFORMATION.—

[(A) If a medical facility finds in evaluating facts for purposes of paragraph (1) that the facts are insufficient to make the determination described in such paragraph, the medical facility shall, in writing, inform the designated officer who submitted the request under subsection (c) of the insufficiency of the facts.

[(B)(i) If a medical facility finds in making a determination under paragraph (1) that the facility possesses no information on whether the victim involved has an infectious disease included on the list under section 2681(a), the medical facility shall, in writing, inform the designated officer who submitted the request under subsection (c) of the insufficiency of such medical information.

[(ii) If after making a response under clause (i) a medical facility determines that the victim involved has an infectious disease, the medical facility shall make the determination described in paragraph (1) and provide the applicable response specified in this subsection.

[(e) TIME FOR MAKING RESPONSE.—After receiving a request under subsection (c) (including any such request resubmitted under subsection (g)(2)), a medical facility shall make the applicable response specified in subsection (d) as soon as is practicable, but not later than 48 hours after receiving the request.

[(f) DEATH OF VICTIM OF EMERGENCY.—

[(1) FACILITY ASCERTAINING CAUSE OF DEATH.—If a victim described in subsection (a) dies at or before reaching the medical facility involved, and the medical facility receives a request under subsection (c), the medical facility shall provide a copy of the request to the medical facility ascertaining the cause of death of the victim, if such facility is a different medical facility than the facility that received the original request.

[(2) RESPONSIBILITY OF FACILITY.—Upon the receipt of a copy of a request for purposes of paragraph (1), the duties otherwise established in this subpart regarding medical facilities shall apply to the medical facility ascertaining the cause of death of the victim in the same manner and to the same extent as such duties apply to the medical facility originally receiving the request.

[(g) ASSISTANCE OF PUBLIC HEALTH OFFICER.—

[(1) EVALUATION OF RESPONSE OF MEDICAL FACILITY REGARDING INSUFFICIENT FACTS.—

[(A) In the case of a request under subsection (c) to which a medical facility has made the response specified in subsection (d)(4)(A) regarding the insufficiency of facts, the public health officer for the community in which the medical facility is located shall evaluate the request and the response, if the designated officer involved submits such documents to the officer with the request that the officer make such an evaluation.

[(B) As soon as is practicable after a public health officer receives a request under paragraph (1), but not later

than 48 hours after receipt of the request, the public health officer shall complete the evaluation required in such paragraph and inform the designated officer of the results of the evaluation.

[(2) FINDINGS OF EVALUATION.—

[(A) If an evaluation under paragraph (1)(A) indicates that the facts provided to the medical facility pursuant to subsection (c) were sufficient for purposes of determinations under subsection (d)(1)—

[(i) the public health officer shall, on behalf of the designated officer involved, resubmit the request to the medical facility; and

[(ii) the medical facility shall provide to the designated officer the applicable response specified in subsection (d).

[(B) If an evaluation under paragraph (1)(A) indicates that the facts provided in the request to the medical facility were insufficient for purposes of determinations specified in subsection (c)—

[(i) the public health officer shall provide advice to the designated officer regarding the collection and description of appropriate facts; and

[(ii) if sufficient facts are obtained by the designated officer—

[(I) the public health officer shall, on behalf of the designated officer involved, resubmit the request to the medical facility; and

[(II) the medical facility shall provide to the designated officer the appropriate response under subsection (c).

[SEC. 2684. PROCEDURES FOR NOTIFICATION OF EXPOSURE.

[(a) CONTENTS OF NOTIFICATION TO OFFICER.—In making a notification required under section 2682 or section 2683(d)(2), a medical facility shall provide—

[(1) the name of the infectious disease involved; and

[(2) the date on which the victim of the emergency involved was transported by emergency response employees to the medical facility involved.

[(b) MANNER OF NOTIFICATION.—If a notification under section 2682 or section 2683(d)(2) is mailed or otherwise indirectly made—

[(1) the medical facility sending the notification shall, upon sending the notification, inform the designated officer to whom the notification is sent of the fact that the notification has been sent; and

[(2) such designated officer shall, not later than 10 days after being informed by the medical facility that the notification has been sent, inform such medical facility whether the designated officer has received the notification.

[SEC. 2685. NOTIFICATION OF EMPLOYEE.

[(a) IN GENERAL.—After receiving a notification for purposes of section 2682 or 2683(d)(2), a designated officer of emergency response employees shall, to the extent practicable, immediately notify each of such employees who—

[(1) responded to the emergency involved; and

[(2) as indicated by guidelines developed by the Secretary, may have been exposed to an infectious disease.

[(b) CERTAIN CONTENTS OF NOTIFICATION TO EMPLOYEE.—A notification under this subsection to an emergency response employee shall inform the employee of—

[(1) the fact that the employee may have been exposed to an infectious disease and the name of the disease involved;

[(2) any action by the employee that, as indicated by guidelines developed by the Secretary, is medically appropriate; and

[(3) if medically appropriate under such criteria, the date of such emergency.

[(c) RESPONSES OTHER THAN NOTIFICATION OF EXPOSURE.—After receiving a response under paragraph (3) or (4) of subsection (d) of section 2683, or a response under subsection (g)(1) of such section, the designated officer for the employee shall, to the extent practicable, immediately inform the employee of the response.

[SEC. 2686. SELECTION OF DESIGNATED OFFICERS.

[(a) IN GENERAL.—For the purposes of receiving notifications and responses and making requests under this subpart on behalf of emergency response employees, the public health officer of each State shall designate 1 official or officer of each employer of emergency response employees in the State.

[(b) PREFERENCE IN MAKING DESIGNATIONS.—In making the designations required in subsection (a), a public health officer shall give preference to individuals who are trained in the provision of health care or in the control of infectious diseases.

[SEC. 2687. LIMITATIONS WITH RESPECT TO DUTIES OF MEDICAL FACILITIES.

[The duties established in this subpart for a medical facility—

[(1) shall apply only to medical information possessed by the facility during the period in which the facility is treating the victim for conditions arising from the emergency, or during the 60-day period beginning on the date on which the victim is transported by emergency response employees to the facility, whichever period expires first; and

[(2) shall not apply to any extent after the expiration of the 30-day period beginning on the expiration of the applicable period referred to in paragraph (1), except that such duties shall apply with respect to any request under section 2683(c) received by a medical facility before the expiration of such 30-day period.

[SEC. 2688. RULES OF CONSTRUCTION.

[(a) LIABILITY OF MEDICAL FACILITIES AND DESIGNATED OFFICERS.—This subpart may not be construed to authorize any cause of action for damages or any civil penalty against any medical facility, or any designated officer, for failure to comply with the duties established in this subpart.

[(b) TESTING.—This subpart may not, with respect to victims of emergencies, be construed to authorize or require a medical facility to test any such victim for any infectious disease.

[(c) CONFIDENTIALITY.—This subpart may not be construed to authorize or require any medical facility, any designated officer of emergency response employees, or any such employee, to disclose

identifying information with respect to a victim of an emergency or with respect to an emergency response employee.

[(d) FAILURE TO PROVIDE EMERGENCY SERVICES.—This subpart may not be construed to authorize any emergency response employee to fail to respond, or to deny services, to any victim of an emergency.

[SEC. 2689. INJUNCTIONS REGARDING VIOLATION OF PROHIBITION.

[(a) IN GENERAL.—The Secretary may, in any court of competent jurisdiction, commence a civil action for the purpose of obtaining temporary or permanent injunctive relief with respect to any violation of this subpart.

[(b) FACILITATION OF INFORMATION ON VIOLATIONS.—The Secretary shall establish an administrative process for encouraging emergency response employees to provide information to the Secretary regarding violations of this subpart. As appropriate, the Secretary shall investigate alleged such violations and seek appropriate injunctive relief.

[SEC. 2690. APPLICABILITY OF SUBPART.

This subpart shall not apply in a State if the chief executive officer of the State certifies to the Secretary that the law of the State is in substantial compliance with this subpart.

PART D—WOMEN, INFANTS, CHILDREN, AND YOUTH

SEC. 2671. GRANTS FOR COORDINATED SERVICES AND ACCESS TO RESEARCH FOR WOMEN, INFANTS, CHILDREN, AND YOUTH.

(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall award grants to public and nonprofit private entities (including a health facility operated by or pursuant to a contract with the Indian Health Service) for the purpose of providing family-centered care involving outpatient or ambulatory care (directly or through contracts) for women, infants, children, and youth with HIV/AIDS.

(b) ADDITIONAL SERVICES FOR PATIENTS AND FAMILIES.—Funds provided under grants awarded under subsection (a) may be used for the following support services:

(1) Family-centered care including case management.

(2) Referrals for additional services including—

(A) referrals for inpatient hospital services, treatment for substance abuse, and mental health services; and

(B) referrals for other social and support services, as appropriate.

(3) Additional services necessary to enable the patient and the family to participate in the program established by the applicant pursuant to such subsection including services designed to recruit and retain youth with HIV.

(4) The provision of information and education on opportunities to participate in HIV/AIDS-related clinical research.

(c) COORDINATION WITH OTHER ENTITIES.—A grant awarded under subsection (a) may be made only if the applicant provides an agreement that includes the following:

(1) The applicant will coordinate activities under the grant with other providers of health care services under this Act, and under title V of the Social Security Act, including programs

promoting the reduction and elimination of risk of HIV/AIDS for youth.

(2) The applicant will participate in the statewide coordinated statement of need under part B (where it has been initiated by the public health agency responsible for administering grants under part B) and in revisions of such statement.

(3) The applicant will every 2 years submit to the lead State agency under section 2617(b)(4) audits regarding funds expended in accordance with this title and shall include necessary client-level data to complete unmet need calculations and Statewide coordinated statements of need process.

(d) ADMINISTRATION; APPLICATION.—A grant may only be awarded to an entity under subsection (a) if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section. Such application shall include the following:

(1) Information regarding how the expected expenditures of the grant are related to the planning process for localities funded under part A (including the planning process outlined in section 2602) and for States funded under part B (including the planning process outlined in section 2617(b)).

(2) A specification of the expected expenditures and how those expenditures will improve overall patient outcomes, as outlined as part of the State plan (under section 2617(b)) or through additional outcome measures.

(e) ANNUAL REVIEW OF PROGRAMS; EVALUATIONS.—

(1) REVIEW REGARDING ACCESS TO AND PARTICIPATION IN PROGRAMS.—With respect to a grant under subsection (a) for an entity for a fiscal year, the Secretary shall, not later than 180 days after the end of the fiscal year, provide for the conduct and completion of a review of the operation during the year of the program carried out under such subsection by the entity. The purpose of such review shall be the development of recommendations, as appropriate, for improvements in the following:

(A) Procedures used by the entity to allocate opportunities and services under subsection (a) among patients of the entity who are women, infants, children, or youth.

(B) Other procedures or policies of the entity regarding the participation of such individuals in such program.

(2) EVALUATIONS.—The Secretary shall, directly or through contracts with public and private entities, provide for evaluations of programs carried out pursuant to subsection (a).

(f) ADMINISTRATIVE EXPENSES.—

(1) LIMITATION.—A grantee may not use more than 10 percent of amounts received under a grant awarded under this section for administrative expenses.

(2) CLINICAL QUALITY MANAGEMENT PROGRAM.—A grantee under this section shall implement a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are

consistent with the guidelines for improvement in the access to and quality of HIV health services.

(g) TRAINING AND TECHNICAL ASSISTANCE.—From the amounts appropriated under subsection (i) for a fiscal year, the Secretary may use not more than 5 percent to provide, directly or through contracts with public and private entities (which may include grantees under subsection (a)), training and technical assistance to assist applicants and grantees under subsection (a) in complying with the requirements of this section.

(h) DEFINITIONS.—In this section:

(1) ADMINISTRATIVE EXPENSES.—The term "administrative expenses" means funds that are to be used by grantees for grant management and monitoring activities, including costs related to any staff or activity unrelated to services or indirect costs.

(2) INDIRECT COSTS.—The term "indirect costs" means costs included in a Federally negotiated indirect rate.

(3) SERVICES.—The term "services" means—

(A) services that are provided to clients to meet the goals and objectives of the program under this section, including the provision of professional, diagnostic, and therapeutic services by a primary care provider or a referral to and provision of specialty care; and

(B) services that sustain program activity and contribute to or help improve services under subparagraph (A).

(i) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated, $71,800,000 for each of the fiscal years 2007 through 2011.

PART E—GENERAL PROVISIONS

SEC. 2681. COORDINATION.

(a) REQUIREMENT.—The Secretary shall ensure that the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Centers for Medicare & Medicaid Services coordinate the planning, funding, and implementation of Federal HIV programs (including all minority AIDS initiatives of the Public Health Service, including under section 2693) to enhance the continuity of care and prevention services for individuals with HIV/AIDS or those at risk of such disease. The Secretary shall consult with other Federal agencies, including the Department of Veterans Affairs, as needed and utilize planning information submitted to such agencies by the States and entities eligible for assistance under this title.

(b) REPORT.—The Secretary shall biennially prepare and submit to the appropriate committees of the Congress a report concerning the coordination efforts at the Federal, State, and local levels described in this section, including a description of Federal barriers to HIV program integration and a strategy for eliminating such barriers and enhancing the continuity of care and prevention services for individuals with HIV/AIDS or those at risk of such disease.

(c) INTEGRATION BY STATE.—As a condition of receipt of funds under this title, a State shall provide assurances to the Secretary that health support services funded under this title will be integrated with other such services, that programs will be coordinated with other available programs (including Medicaid), and that the

continuity of care and prevention services of individuals with HIV/AIDS is enhanced.

(d) INTEGRATION BY LOCAL OR PRIVATE ENTITIES.—As a condition of receipt of funds under this title, a local government or private nonprofit entity shall provide assurances to the Secretary that services funded under this title will be integrated with other such services, that programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

SEC. 2682. AUDITS.

(a) IN GENERAL.—For fiscal year 2009, and each subsequent fiscal year, the Secretary may reduce the amounts of grants under this title to a State or political subdivision of a State for a fiscal year if, with respect to such grants for the second preceding fiscal year, the State or subdivision fails to prepare audits in accordance with the procedures of section 7502 of title 31, United States Code. The Secretary shall annually select representative samples of such audits, prepare summaries of the selected audits, and submit the summaries to the Congress.

(b) POSTING ON THE INTERNET.—All audits that the Secretary receives from the State lead agency under section 2617(b)(4) shall be posted, in their entirety, on the Internet website of the Health Resources and Services Administration.

SEC. 2683. PUBLIC HEALTH EMERGENCY.

(a) IN GENERAL.—In an emergency area and during an emergency period, the Secretary shall have the authority to waive such requirements of this title to improve the health and safety of those receiving care under this title and the general public, except that the Secretary may not expend more than 5 percent of the funds allocated under this title for sections 2620 and section 2603(b).

(b) EMERGENCY AREA AND EMERGENCY PERIOD.—In this section:

(1) EMERGENCY AREA.—The term "emergency area" means a geographic area in which there exists—

(A) an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; or

(B) a public health emergency declared by the Secretary pursuant to section 319.

(2) EMERGENCY PERIOD.—The term "emergency period" means the period in which there exists—

(A) an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; or

(B) a public health emergency declared by the Secretary pursuant to section 319.

(c) UNOBLIGATED FUNDS.—If funds under a grant under this section are not expended for an emergency in the fiscal year in which the emergency is declared, such funds shall be returned to the Secretary for reallocation under sections 2603(b) and 2620.

SEC. 2684. PROHIBITION ON PROMOTION OF CERTAIN ACTIVITIES.

None of the funds appropriated under this title shall be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual. Funds authorized under this

title may be used to provide medical treatment and support services for individuals with HIV.

SEC. 2685. PRIVACY PROTECTIONS.

(a) IN GENERAL.—The Secretary shall ensure that any information submitted to, or collected by, the Secretary under this title excludes any personally identifiable information.

(b) DEFINITION.—In this section, the term "personally identifiable information" has the meaning given such term under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

SEC. 2686. GAO REPORT.

The Comptroller General of the Government Accountability Office shall biennially submit to the appropriate committees of Congress a report that includes a description of Federal, State, and local barriers to HIV program integration, particularly for racial and ethnic minorities, including activities carried out under subpart III of part F, and recommendations for enhancing the continuity of care and the provision of prevention services for individuals with HIV/AIDS or those at risk for such disease. Such report shall include a demonstration of the manner in which funds under this subpart are being expended and to what extent the services provided with such funds increase access to prevention and care services for individuals with HIV/AIDS and build stronger community linkages to address HIV prevention and care for racial and ethnic minority communities.

SEC. 2687. DEFINITIONS.

For purposes of this title:

(1) AIDS.—The term "AIDS" means acquired immune deficiency syndrome.

(2) CO-OCCURRING CONDITIONS.—The term "co-occurring conditions" means one or more adverse health conditions in an individual with HIV/AIDS, without regard to whether the individual has AIDS and without regard to whether the conditions arise from HIV.

(3) COUNSELING.—The term "counseling" means such counseling provided by an individual trained to provide such counseling.

(4) FAMILY-CENTERED CARE.—The term "family-centered care" means the system of services described in this title that is targeted specifically to the special needs of infants, children, women and families. Family-centered care shall be based on a partnership between parents, professionals, and the community designed to ensure an integrated, coordinated, culturally sensitive, and community-based continuum of care for children, women, and families with HIV/AIDS.

(5) FAMILIES WITH HIV/AIDS.—The term "families with HIV/AIDS" means families in which one or more members have HIV/AIDS.

(6) HIV.—The term "HIV" means infection with the human immunodeficiency virus.

(7) HIV/AIDS.—

(A) IN GENERAL.—The term "HIV/AIDS" means HIV, and includes AIDS and any condition arising from AIDS.

(B) COUNTING OF CASES.—The term "living cases of HIV/AIDS", with respect to the counting of cases in a geographic area during a period of time, means the sum of—

(i) the number of living non-AIDS cases of HIV in the area; and

(ii) the number of living cases of AIDS in the area.

(C) NON-AIDS CASES.—The term "non-AIDS", with respect to a case of HIV, means that the individual involved has HIV but does not have AIDS.

(8) HUMAN IMMUNODEFICIENCY VIRUS.—The term "human immunodeficiency virus" means the etiologic agent for AIDS.

(9) OFFICIAL POVERTY LINE.—The term "official poverty line" means the poverty line established by the Director of the Office of Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

(10) PERSON.—The term "person" includes one or more individuals, governments (including the Federal Government and the governments of the States), governmental agencies, political subdivisions, labor unions, partnerships, associations, corporations, legal representatives, mutual companies, joint-stock companies, trusts, unincorporated organizations, receivers, trustees, and trustees in cases under title 11, United States Code.

(11) STATE.—

(A) IN GENERAL.—The term "State" means each of the 50 States, the District of Columbia, and each of the territories.

(B) TERRITORIES.—The term "territory" means each of American Samoa, Guam, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, the Virgin Islands, the Republic of the Marshall Islands, the Federated States of Micronesia, and Palau.

(12) YOUTH WITH HIV.—The term "youth with HIV" means individuals who are 13 through 24 years old and who have HIV/AIDS.

PART F—DEMONSTRATION AND TRAINING

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[SUBPART I—SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

[SEC. 2691. SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE.

[(a) IN GENERAL.—Of the amount appropriated under each of parts A, B, C, and D of this title for each fiscal year, the Secretary shall use the greater of $20,000,000 or 3 percent of such amount appropriated under each such part, but not to exceed $25,000,000, to administer a special projects of national significance program to award direct grants to public and nonprofit private entities including community-based organizations to fund special programs for the care and treatment of individuals with HIV disease.

[(b) GRANTS.—The Secretary shall award grants under subsection (a) based on—

[(1) the need to assess the effectiveness of a particular model for the care and treatment of individuals with HIV disease;

[(2) the innovative nature of the proposed activity; and

[(3) the potential replicability of the proposed activity in other similar localities or nationally.

[(c) SPECIAL PROJECTS.—Special projects of national significance shall include the development and assessment of innovative service delivery models that are designed to—

[(1) address the needs of special populations;

[(2) assist in the development of essential community-based service delivery infrastructure; and

[(3) ensure the ongoing availability of services for Native American communities to enable such communities to care for Native Americans with HIV disease.

[(d) SPECIAL POPULATIONS.—Special projects of national significance may include the delivery of HIV health care and support services to traditionally underserved populations including—

[(1) individuals and families with HIV disease living in rural communities;

[(2) adolescents with HIV disease;

[(3) Indian individuals and families with HIV disease;

[(4) homeless individuals and families with HIV disease;

[(5) hemophiliacs with HIV disease; and

[(6) incarcerated individuals with HIV disease.

[(e) SERVICE DEVELOPMENT GRANTS.—Special projects of national significance may include the development of model approaches to delivering HIV care and support services including—

[(1) programs that support family-based care networks and programs that build organizational capacity critical to the delivery of care in minority communities;

[(2) programs designed to prepare AIDS service organizations and grantees under this title for operation within the changing health care environment; and

[(3) programs designed to integrate the delivery of mental health and substance abuse treatment with HIV services.

[(f) COORDINATION.—The Secretary may not make a grant under this section unless the applicant submits evidence that the proposed program is consistent with the statewide coordinated statement of need, and the applicant agrees to participate in the ongoing revision process of such statement of need.

[(g) REPLICATION.—The Secretary shall make information concerning successful models developed under this part available to grantees under this title for the purpose of coordination, replication, and integration. To facilitate efforts under this subsection, the Secretary may provide for peer-based technical assistance from grantees funded under this part.]

SUBPART I—SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

SEC. 2691. SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE.

(a) IN GENERAL.—Of the amount appropriated under each of parts A, B, C, and D for each fiscal year, the Secretary shall use the greater of $20,000,000 or an amount equal to 3 percent of such amount appropriated under each such part, but not to exceed $25,000,000, to administer special projects of national significance to—

(1) quickly respond to emerging needs of individuals receiving assistance under this title; and

(2) to fund special programs to develop a standard electronic client information data system to improve the ability of grantees under this title to report client-level data to the Secretary.

(b) GRANTS.—The Secretary shall award grants under subsection (a) to entities eligible for funding under parts A, B, C, and D based on—

(1) whether the funding will promote obtaining client level data as it relates to the creation of a severity of need index under section 2618(a)(2)(E), including funds to facilitate the purchase and enhance the utilization of qualified health information technology systems;

(2) demonstrated ability to create and maintain a qualified health information technology system;

(3) the potential replicability of the proposed activity in other similar localities or nationally;

(4) the demonstrated reliability of the proposed qualified health information technology system across a variety of providers, geographic regions, and clients; and

(5) the demonstrated ability to maintain a safe and secure qualified health information system; or

(6) newly emerging needs of individuals receiving assistance under this title.

(c) COORDINATION.—The Secretary may not make a grant under this section unless the applicant submits evidence that the proposed program is consistent with the statewide coordinated statement of need, and the applicant agrees to participate in the ongoing revision process of such statement of need.

(d) PRIVACY PROTECTION.—The Secretary may not make a grant under this section for the development of a qualified health information technology system unless the applicant provides assurances to the Secretary that the system will, at a minimum, comply with the privacy regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

(e) REPLICATION.—The Secretary shall make information concerning successful models or programs developed under this part available to grantees under this title for the purpose of coordination, replication, and integration. To facilitate efforts under this subsection, the Secretary may provide for peer-based technical assistance for grantees funded under this part.

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SUBPART II—AIDS EDUCATION AND TRAINING CENTERS

SEC. 2692. HIV/AIDS COMMUNITIES, SCHOOLS, AND CENTERS.

(a) SCHOOLS; CENTERS.—

(1) IN GENERAL.—The Secretary may make grants and enter into contracts to assist public and nonprofit private entities and schools and academic health science centers in meeting the costs of projects—

(A) to train health personnel, including practitioners in programs under this title and other community providers, in the diagnosis, treatment, and prevention of HIV disease, including the prevention of the perinatal transmission of the disease, including measures for the prevention and treatment of opportunistic infections, and including (as ap-

plicable to the type of health professional involved), prenatal and other gynecological care for women with HIV disease;

(B) to train the faculty of schools of, and graduate departments or programs of, medicine, nursing, osteopathic medicine, dentistry, public health, allied health, and mental health practice to teach health professions students to provide for the health care needs of individuals with HIV disease;

* * * * * * *

(D) to develop protocols for the medical care of women with HIV disease, including prenatal and other gynecological care for such women.

(2) PREFERENCE IN MAKING GRANTS.—In making grants under paragraph (1), the Secretary shall give preference to qualified projects which will—

(A) train, or result in the training of, health professionals who will provide treatment for minority individuals and Native Americans with HIV disease and other individuals who are at high risk of contracting such disease;

(B) train, or result in the training of, minority health professionals and minority allied health professionals to provide treatment for individuals with such disease; andK

(C) train or result in the training of health professionals and allied health professionals to provide treatment for hepatitis B or C co-infected individuals.

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(b) DENTAL SCHOOLS.—

(1) IN GENERAL.—

(A) GRANTS.—The Secretary may make grants to dental schools and programs described in subparagraph (B) to assist such schools and programs with respect to oral health care to patients with [HIV disease] *HIV/AIDS*.

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(2) APPLICATION.—Each dental school or program described in section the section referred to in paragraph (1)(B) may annually submit an application documenting the unreimbursed costs of oral health care provided to patients with [HIV disease] *HIV/AIDS* by that school or hospital during the prior year.

(3) DISTRIBUTION.—The Secretary shall distribute the available funds among all eligible applicants, taking into account the number of patients with [HIV disease] *HIV/AIDS* served and the unreimbursed oral health care costs incurred by each institution as compared with the total number of patients served and costs incurred by all eligible applicants.

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(5) COMMUNITY-BASED CARE.—The Secretary may make grants to dental schools and programs described in paragraph (1)(B) that partner with community-based dentists to provide oral health care to patients with [HIV disease] *HIV/AIDS* in unserved areas. Such partnerships shall permit the training of

dental students and residents and the participation of community dentists as adjunct faculty.

[(c) AUTHORIZATION OF APPROPRIATIONS.—

[(1) SCHOOLS; CENTERS.—For the purpose of grants under subsection (a), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

[(2) DENTAL SCHOOLS.—

[(A) IN GENERAL.—For the purpose of grants under paragraphs (1) through (4) of subsection (b), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

[(B) COMMUNITY-BASED CARE.—For the purpose of grants under subsection (b)(5), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.]

(c) AUTHORIZATION OF APPROPRIATIONS.—

(1) SCHOOLS; CENTERS.—For the purpose of awarding grants under subsection (a), there is authorized to be appropriated $34,700,000 for each of the fiscal years 2007 through 2011.

(2) DENTAL SCHOOLS.—For the purpose of awarding grants under subsection (b), there is authorized to be appropriated $13,000,000 for each of the fiscal years 2007 through 2011.

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SUBPART III—MINORITY AIDS INITIATIVE

SEC. 2693. MINORITY AIDS INITIATIVE.

(a) IN GENERAL.—For the purpose of carrying out activities under this section to evaluate and address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities (including African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders), there are authorized to be appropriated $131,200,000 for fiscal year 2007, $135,100,000 for fiscal year 2008, $139,100,000 for fiscal year 2009, $143,200,000 for fiscal year 2010, and $147,500,000 for fiscal year 2011.

(b) CERTAIN ACTIVITIES.—

(1) IN GENERAL.—In carrying out the purpose described in subsection (a), the Secretary shall provide for—

(A) emergency assistance under part A;

(B) care grants under part B;

(C) early intervention services under part C;

(D) services through projects for HIV-related care under part D; and

(E) activities through education and training centers under section 2692.

(2) ALLOCATIONS AMONG ACTIVITIES.—Activities under paragraph (1) shall be carried out by the Secretary in accordance with the following:

(A) For competitive, supplemental grants to improve HIV-related health outcomes to reduce existing racial and ethnic health disparities, the Secretary shall, of the amount appropriated under subsection (a) for a fiscal year, reserve the following, as applicable:

(i) For fiscal year 2007, $43,800,000.
(ii) For fiscal year 2008, $45,400,000.
(iii) For fiscal year 2009, $47,100,000.
(iv) For fiscal year 2010, $48,800,000.
(v) For fiscal year 2011, $50,700,000.

(B) For competitive grants used for supplemental support education and outreach services to increase the number of eligible racial and ethnic minorities who have access to treatment through the program under section 2616 for therapeutics, the Secretary shall, of the amount appropriated for a fiscal year under subsection (a), reserve the following, as applicable:

(i) For fiscal year 2007, $7,000,000.
(ii) For fiscal year 2008, $7,300,000.
(iii) For fiscal year 2009, $7,500,000.
(iv) For fiscal year 2010, $7,800,000.
(v) For fiscal year 2011, $8,100,000.

(C) For planning grants, capacity-building grants, and services grants to health care providers who have a history of providing culturally and linguistically appropriate care and services to racial and ethnic minorities, the Secretary shall, of the amount appropriated for a fiscal year under subsection (a), reserve the following, as applicable:

(i) For fiscal year 2007, $53,400,000.
(ii) For fiscal year 2008, $55,400,000.
(iii) For fiscal year 2009, $57,400,000.
(iv) For fiscal year 2010, $59,500,000.
(v) For fiscal year 2011, $61,800,000.

(D) For eliminating racial and ethnic disparities in the delivery of comprehensive, culturally and linguistically appropriate care services for HIV disease for women, infants, children, and youth, the Secretary shall, of the amount appropriated under subsection (a), reserve $18,500,000 for each of the fiscal years 2007 through 2011.

(E) For increasing the training capacity of centers to expand the number of health care professionals with treatment expertise and knowledge about the most appropriate standards of HIV disease-related treatments and medical care for racial and ethnic minority adults, adolescents, and children with HIV disease, the Secretary shall, of the amount appropriated under subsection (a), reserve $8,500,000 for each of the fiscal years 2007 through 2011.

(c) CONSISTENCY WITH PRIOR PROGRAM.—With respect to the purpose described in subsection (a), the Secretary shall carry out this section consistent with the activities carried out under this title by the Secretary pursuant to the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2002 (Public Law 107–116).

DISSENTING VIEWS OF REPRESENTATIVES HENRY A. WAXMAN, LOIS CAPPS, ANNA G. ESHOO, AND HILDA L. SOLIS

We reluctantly opposed the Ryan White HIV/AIDS Treatment Modernization Act of 2006 as reported by the House Committee on Energy and Commerce on September 20, 2006. This legislation has far-reaching implications for the stability of HIV/AIDS funding in our State and cities. The programs funded by the Ryan White Care Act have literally been life-savers for people who live with HIV/AIDS. The Act has provided critical support to the cities that have been the center of the epidemic, and to our State funding critical drug and support programs to treat the disease.

In prior reauthorizations of the Ryan White Care Act, the changes that have been made were made at the margins in order to deal with emerging problems and developments. These changes did not, however, disrupt the overall program that was working effectively. Unfortunately, unlike those past reauthorizations, this Committee-reported bill would have a drastic destabilizing effect on many of the hardest-hit areas of the country, including California.

Had this Administration and the Republican-controlled Congress prioritized the Ryan White program in making its budget allocations over the past several years, we would not be writing these dissenting views. The Committee-reported bill seeks to apportion an inadequate amount of money that is simply not enough to meet the current demand for HIV/AIDS care in the United States. The Towns/Eshoo/Engel/Capps Amendment offered at the markup would have addressed this concern to some extent by injecting much-needed additional dollars into the program. That amendment was regrettably voted down largely along party lines.

The Pallone amendment also would have been a productive step. That amendment would have maintained the status quo for one year and removed the threat of damaging massive shifts in funds, thereby allowing the negotiation process to continue. Again, this amendment was voted down largely along party lines.

There are several other problems with the way in which the bill seeks to allocate Ryan White funds that are of significant concern to our State. The first relates to incorporating data on HIV cases into the funding formula. The 2000 reauthorization of the Act included a requirement that HIV cases be incorporated into the funding distribution by no later than 2007. At that time, HIV reporting systems were in various stages of development across the country; although some states and cities had been reporting HIV cases by name since 1985, others had yet to implement an HIV-reporting system at all. Given this landscape, the drafters understood the need to provide sufficient time to allow states and cities to begin collecting HIV cases. At the time, they believed seven years to be adequate for such a transition. As it turns out, it was not.

As HIV reporting systems were developed, variations among these systems across jurisdictions emerged. Some areas reported HIV by the individual's name along with other identifying information. California and many other states, as a means of protecting the individual's confidentiality, opted not to report the person's name at all, and instead included only a unique code identifying the individual. The 2000 reauthorization of the Ryan White Act did not specify which type of reporting system jurisdictions were required to use and nothing in the law prohibited this kind of variation. So long as the Secretary found that the data on HIV cases was "sufficiently accurate and reliable," jurisdictions were free to report cases by name or by code. Thus, whether an area began collecting HIV by name or by code, they were on equally solid ground under the law.

It was not until December 2005, that CDC first gave a definitive indication that it would deem only cases reported by name to be "sufficiently accurate and reliable." In a letter to all code-based states, CDC set forth its strong recommendation that those states convert to a names-based system—it did not, however, establish any sort of legal requirement. At that point, 13 states used some form of a code-based reporting system. In response to CDC's announcement, almost all code-based states began the process of moving to names-based systems.

The reported bill would rely exclusively on names-based HIV and AIDS cases in making funding allocations starting in fiscal year 2011. In order to meet this deadline, and have all of their names-based HIV cases counted for funding purposes, code-based jurisdictions will be required to have completely converted to names-based systems in less than three years.

For large and diverse code-based states with several very large cities, such as California, this is simply not enough time to make this change. California essentially has to start from scratch. In its code-based system, California currently has approximately 40,000 cases of HIV (non-AIDS). Under California law, these cases cannot simply be re-tallied under the new names-based system. In order to incorporate these cases into the new system, the State must contact each of these 40,000 individuals, and ask them to come in to a testing site to be re-tested. Some of these individuals are homeless. Some are drug-abusers. Many don't speak English. Given that personnel and resources are already strained, California will simply not be able to get all of these individuals entered into the names-based system in three years.

The experience of other large code-based systems provides a sense of the difficulty of this task. New York, for example, converted to a names-based system in 2000 and is now considered by CDC to be mature. However, it is widely acknowledged that New York's current names-based HIV count severely undercounts the true burden of HIV in the State. New York simply has not had enough time to find and report all of its HIV cases.

We cannot support legislation that would disadvantage our State and take large amounts of dollars away simply because the data system is incomplete. The number of persons with HIV and with need for services remains. They should not lose needed services because of an unrealistic data requirement.

Because HIV reporting systems across the country remain in a state of flux, it is critical that this reauthorization protect against severe losses in funding if it seeks to base the funding on HIV cases. The most effective way to accomplish this protection is to incorporate a hold-harmless provision for the entire life of the bill. Unfortunately, the current bill protects a jurisdiction's funding for only the first three years. This is not enough.

Under the bill, California faces the most drastic cuts at the very time the hold harmless comes to an end. By California's estimates, the State stands to lose nearly 25 percent of its total RWCA funding during the fifth year of the bill alone. Our State simply cannot sustain these kinds of losses.

The bill's so-called "priority language" is also not a solution. The bill includes language within the Title I and Title II supplement grants that would permit—but not require—the Secretary to allocate supplement dollars to areas that successfully prove they suffered a decline in funding that negatively impacts their provision of Ryan White services. The discretionary nature of this provision is concerning; there is no guarantee that the Secretary would agree that a given state has adequately demonstrated a decrease in its ability to provide services. However, perhaps more concerning, it is unclear whether funds will be available to make these grants even if the Secretary decided an area had shown that it met the criteria. Despite the fact that there are several changes scheduled to occur mid-way through the life of the bill, i.e., the shift to names-based data and the termination of the hold-harmless protection, the data runs provided by GAO were limited to one year only. Thus the overall funding picture is entirely unknown and we cannot assume that the dollars needed to fund these so-called priority grants would be available.

The bill also unfairly penalizes code-based jurisdictions by applying a 5 percent gain cap only to those areas—and not to other names-based jurisdictions. It is unacceptable to punish a code-based state because they adopted their system in good faith and collected HIV data that they thought would be in compliance with the requirements of the law. However, this cap has another important and negative effect: by failing to cap the gains across the board, it further depletes the funds necessary to make "priority grants." Further, the very same states that had limits on any increases in funds during the early years of this reauthorization are denied protection against massive losses in the later years.

We also cannot support the bill's inclusion of the so-called "severity of need index" (SONI). The bill requires the Secretary to develop a SONI to measure the relative needs of individuals living with HIV/AIDS. But the bill fails to specify the factors that should be incorporated into this index, leaving this determination entirely up to the Secretary. Further, the bill then permits the Secretary to completely discard the current funding formula and distribute funding on the basis of this SONI beginning as early as FY 2011 without Congressional action. This is unacceptable. Congress—not the Administration—should be solely responsible for making such a drastic shift in the way funds are distributed under the Act.

A basic goal of this reauthorization must be ensuring that the actions we take do not destabilize systems already in place serving

this population. Unfortunately, the Committee-reported bill fails to meet this goal and jeopardizes the critical funding of areas throughout the country in general, and the State and cities of California in particular.

For all of these reasons, we oppose the Ryan White HIV/AIDS Treatment Modernization Act of 2006 as reported by the House Committee on Energy and Commerce on September 20, 2006.

HENRY A. WAXMAN.
LOIS CAPPS.
ANNA G. ESHOO.
HILDA L. SOLIS.

DISSENTING VIEWS OF REPRESENTATIVES FRANK PALLONE, JR., ELIOT L. ENGEL, HENRY A. WAXMAN, EDWARD J. MARKEY, EDOLPHUS TOWNS, ANNA G. ESHOO, LOIS CAPPS, AND HILDA L. SOLIS

THIS LEGISLATION FAILS TO PROVIDE ADEQUATE FUNDING TO PROVIDE TREATMENT TO HIV/AIDS PATIENTS

The "Ryan White HIV/AIDS Treatment Modernization Act of 2006", as reported out by the Committee, fails to provide states, metropolitan areas, and other grantees with the resources necessary to meet the growing need of their HIV/AIDS populations.

This reauthorization will destabilize established systems of care and will have a devastating effect on the ability of high-prevalence communities to address need. While the HIV/AIDS epidemic has expanded, more than ½ of all people living with AIDS in the United States reside in just five states: New York, California, Florida, Texas and New Jersey. Under H.R. 6143, three of the five highest prevalence states (NY, FL, NJ) will suffer devastating funding losses, which will compromise their ability to provide comprehensive medical care and services to their HIV/AIDS population.

As thousands of new infections are diagnosed annually, and people continue to live longer thanks to new life-saving drug therapies, the demand for treatment and support services funded by the Ryan White CARE Act are increasing rapidly. Unfortunately, as the demand for services continue to grow Republicans have flat funded the CARE Act for the past five fiscal years, thereby limiting the ability of grantees to provide necessary care. According to the AIDS Institute, there are presently over 230,000 people in the United States who are not receiving antiretroviral treatment who should be, and there is a growing unmet need for HIV/AIDS health care services.

In spite of these facts, the bill reported out of the Committee would authorize flat funding for fiscal year 2007, and only increase authorizations of appropriations by 3.7% through fiscal year 2011 to account for inflation. As a result, this bill will still do very little to actually help alleviate the growing unmet need for HIV/AIDS treatment services in our communities.

TOWNS/ESHOO/ENGEL/CAPPS AMENDMENT

We support increasing authorization levels above inflation in order to help our communities improve access to care for those persons and families affected by HIV/AIDS. Accordingly, Representatives Towns and Engel of New York and Representatives Eshoo and Capps of California offered a joint amendment that would have significantly increased authorizations above inflation for the life of the authorization period. Title I Formula and Title I Supplemental funding would have been increased by $120,320,405 total over five

years and Title II Base, Title II Supplemental and ADAP funding would have been increased by $312,322,900 total over five years.

In addition, the amendment would have extended the hold harmless of 95% of the previous fiscal year funding for all five years of the reauthorization. The current bill fails to provide states with funding certainty by ending the hold harmless after three years.

Unfortunately, the Towns/Eshoo/Engel/Capps amendment was defeated largely along party lines.

PALLONE SUBSTITUTE AMENDMENT

Representative Pallone of New Jersey offered an amendment in the nature of a substitute to reauthorize the Ryan White CARE Act through fiscal year 2007. Furthermore, the substitute amendment would have increased authorization levels by 3.7% to account for inflationary increases and prevents any unspent funds from reverting back to the treasury; a one time emergency authorization of $30 million in Title II for areas that have unmet need and receive no funding under Title I of the Act; and a one year extension of the names based reporting requirement.

We believe that the bill taken up and ultimately reported out of Committee is substantially flawed. First, as outlined above, the bill is woefully under funded. Second, the funding problem is exacerbated by the fact that the bill would add HIV to the formula used to allocate money for the first time. We are not opposed to counting HIV cases for the purposes of distributing money. However, the impact of counting these cases should not result in the loss of funding for those cities and/or states that have a disproportionate share of AIDS cases, such as New York and New Jersey, which have consistently been the hardest hit in this epidemic's history.

We remain concerned that states' differing HIV surveillance systems will prevent funding from accurately following the epidemic. Within the bill, the dual track reporting system mandates separate standards for HIV reporting for states with code-based reporting systems versus those who report by name. The 33 "name-based" states are currently held to rigorous CDC validation requirements and restrictions while those who are code-based will eventually report to a system that is not yet developed. Further, the proposed arbitrary five-percent duplication penalty is problematic in light of the fact that duplication varies widely from state to state, with some states showing a duplication rate that exceeds five percent and some states below five percent. Since "code-based" states are also subject to a five percent gain cap in funding until their HIV surveillance systems are deemed mature, it is clear that regardless of code or name status, many states will not receive appropriate funding for their HIV populations.

Finally, it is troubling that the committee has been given only one year of data that is questionable at best to evaluate the impact of this five year reauthorization and thus the full impact of this legislation is unknown. The Pallone amendment would provide further opportunity to clarify the real impact of the legislation by using data that actually would be used to determine formula distribution.

Given all of these concerns, we feel that it is appropriate to delay the implementation of a funding formula that includes HIV data

and postpone further action on the bill so that all parties can continue negotiations and reach an agreement that addresses our concerns and keeps all of our systems of care intact.

Unfortunately, the Pallone substitute amendment was defeated largely along party lines.

CONCERNS ABOUT SEVERITY OF NEED INDEX

We remain concerned that implementing the Severity of Need Index (SONI) may further exacerbate funding shifts and uncertainty. H.R. 6143 calls for the SONI to be used to allocate Title II formula funding as early as FY11 and no later than FY13 without Congressional action, despite the fact that the structure and impact of such an index cannot be determined. We are concerned that the SONI may consider the generosity of a state Medicaid program or other available state or local resources when determining Ryan White funding allocations. Factoring the contribution of state and local dollars into the formula essentially punishes jurisdictions taking responsibility upon themselves to care for their HIV/AIDS population, creating a powerful disincentive for state and local action.

Mandating an index that has yet to be developed and tested is premature—particularly in light of the fact that national data on HIV cases are not expected to be mature and universally available for several years. We strongly believe that the Severity of Need Index should not be used to allocate federal funding until the next Ryan White CARE Act reauthorization.

CONCERNS ABOUT PRIORITY GRANT LANGUAGE

The language related to priority grants for jurisdictions that experience losses is not consistent with the commitment that was made to address reductions in resources. The bicameral, bipartisan staff of Senators Enzi and Kennedy and Congressmen Barton and Dingell met with Governors' representatives on September 12, 2006, to brief them on the bill and to obtain feedback. During the meeting, a commitment was made by the staff to "make states whole" relative to FY06 funding. Governors' representatives were informed that there are sufficient funds in the bill to address the following in priority order: (1) hold harmless provisions; (2) priority grants to ensure that jurisdictions are made whole; and (3) grants for demonstrated need. The priority grants were described as a stopgap measure. Despite efforts to negotiate priority grant language that was consistent with the commitment made to the Governors and to Members of the House Energy and Commerce Committee and Senate Committee on Health, Education, Labor, and Pensions Committee, a compromise that was acceptable to all could not be reached. The language in the bill does not represent a commitment to make jurisdictions whole; rather, the language calls for competitive grants and leaves to the discretion of the secretary whether to make a priority grant to a jurisdiction that has experienced a reduction as well as the level of priority funding.

Finally, despite assurances that there is enough funding in the bill to achieve the goal to make states and Title I jurisdictions whole to FY06 funding, due to the numerous changes being made to the bill and the lack of data demonstrating the impact of the bill

in each year of the authorization period, we are unconvinced that states and Title I jurisdictions will receive funding restoration.

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